



Formal Regional Consultation on the International Health Regulations

Focusing on the document by the WHO Secretariat

[Draft] Five-year global strategic plan to improve public health preparedness and response

São Paulo, Brazil, 17-19 July 2017

Final Report

Executive Summary

Key concerns, comments, and suggestions formulated by States Parties in the Americas during the 2015, 2016, and 2017 Formal Regional Consultations, held to expedite the revision and finalization of both, the draft *Five-year global strategic plan to improve public health preparedness and response* (Draft GSP) and the proposed *Monitoring and Evaluation Framework for the International Health Regulations* (IHR MEF), through the Governing Bodies of the Pan American Health Organization (PAHO) and World Health Organization (WHO), are summarized below.

- In compliance with Article 54, “Reporting and review,” the vast majority of countries recommended that the IHR MEF should be presented as a stand-alone document, separate from the Draft GSP, for consideration and adoption by the Seventy-first World Health Assembly in May 2018, through the WHO Executive Board at its 142nd session, January 2018.
- The WHO Secretariat should take into account the following considerations as it works to shape future iterations of the Draft GSP in the context of the ongoing consultative process:
 - In its current form, the Draft GSP is more operational than strategic in nature. Therefore, it needs to be revised in order to acquire the desired strategic breadth, especially with respect to strategic pillars 2 and 3.
 - *Strategic pillar 1 - Building and maintaining State Parties Core Capacities:* This pillar should *i)* present a conceptual framework that bridges core capacities detailed in Annex 1 of the IHR and essential public health functions, and *ii)* reflect the wide variation across States Parties with respect to both the maturity of their health systems and the status of their application and implementation of the IHR,

in order to explicitly overcome the one-size-fits-all concept of a “dedicated national IHR plan.”

- *Strategic pillar 2 - Event management and compliance* and *Strategic pillar 3 - Measuring progress and accountability*: These pillars need to be reshaped because *i)* the responsibility to demonstrate accountability falls exclusively upon States Parties; *ii)* the IHR MEF Framework only covers a subset of provisions related to core capacities; and *iii)* the proposed monitoring of compliance with IHR provisions is restricted to States Parties’ obligations under Article 43.
- The development of a stand-alone five-year regional operational plan, separate from the PAHO Biennial Work Plans (2018-2019 and beyond), is not considered necessary. Additionally, the Sustainable Health Agenda for the Americas 2018-2030 (12) comprehensively encompasses IHR-related issues.
- To bring closure to years of debates within the PAHO and WHO Governing Bodies, the IHR MEF should be revised as part of the ongoing consultative process. The proposal developed during the 2017 Consultation seeks to find an acceptable common ground that can bridge increasingly polarized positions among States Parties. Therefore, taking into account comments expressed during the 2015 and 2016 Consultations, the IHR MEF, for each of its four components, should present *i)* the public health rationale and objectives; *ii)* roles and responsibilities of States Parties and the WHO Secretariat; *iii)* the extent to which the component complements the other components, with related considerations of cost-effectiveness; *iv)* explicit references to the tool or tools supporting the roll-out of the component, and the process underlying the tools’ development adopted by the WHO Secretariat; *v)* the frequency of the component’s implementation; *vi)* a description of the type of information that will be presented to the World Health Assembly resulting from the application of the component; *vii)* how the information produced by the application of the component will be used by the WHO Secretariat to inform its country cooperation activities.
- The outline of the process for conducting voluntary joint external evaluations in the Americas proposed by PASB was generally accepted.
- Extensive comments and suggestions provided by States Parties in the Region during the 2015 and 2016 Consultations, related to both the Draft GSP and the IHR MEF, are still valid and should be considered by the WHO Secretariat as part of the ongoing consultative process.
- For the ongoing consultative process, the WHO Secretariat should adopt a more transparent approach than was used in 2015 and 2016 for consolidating the inputs received from States Parties.

Introduction

1. The Formal Regional Consultation on the International Health Regulations (hereafter referred to as the “meeting” or “Consultation”) was held in São Paulo, Brazil, from 17 to 19 July 2017. The International Health Regulations are hereafter referred to as “IHR” or “Regulations.”

Objectives

2. In compliance with Decision WHA70(11)¹, through which WHO Member States requested the Director-General of WHO “to develop, in full consultation with Member States, including through the regional committees, a draft five-year global strategic plan to improve public health preparedness and response, based on the guiding principles contained in Annex 2 of document A70/16, to be submitted for consideration and adoption by the Seventy-first World Health Assembly, through the Executive Board at its 142nd session,” the objectives of the Consultation were:

- a) To contribute to the global consultative process for the elaboration of the final draft of the document prepared by the WHO Secretariat, *Five-year global strategic plan to improve public health preparedness and response - Consultation with Member States* (hereafter referred to as “Draft GSP,” Annex A);
- b) To propose a way forward in relation to the IHR Monitoring and Evaluation Framework (hereafter referred to as “IHR MEF” or “Framework”);
- c) To contribute to the elaboration of the Five-year Regional Operational Plan for the Americas;
- d) To inform the discussions and deliberations of the 29th Pan American Sanitary Conference/69th Session of the Regional Committee of WHO for the Americas, Washington, D.C., United States, 25-29 September 2017.

Participants

3. Each of the 35 States Parties in the Region was invited to designate two officials with the following profiles to participate in the meeting:

- a) A government official with intra- and intersectoral coordinating function of the application and implementation of the IHR and with thorough knowledge and understanding of IHR provisions and related PAHO and WHO Governing Bodies documents;
- b) A government official with decision-making power in relation to the application of, implementation of, and compliance with the IHR and informed of WHO and PAHO Governing Bodies’ processes and procedures.

4. Thirty (30) States Parties were represented at the meeting (Annex C). Barbados, Cuba, Saint Kitts and Nevis, Saint Vincent and the Grenadines, and Venezuela were unable to attend. Additionally, professionals from the Region, including members of the IHR Roster of

¹ World Health Organization. Implementation of the International Health Regulations (2005) [Internet]. 70th World Health Assembly; 2017 May 22-31; Geneva. Geneva: WHO; 2017 (Decision WHA70[11]) [cited 2017 August 15]. Available from: http://apps.who.int/gb/ebwha/pdf_files/WHA70/A70_Div3-en.pdf.

Experts, were mobilized by PASB to facilitate the working group sessions together with PAHO staff from four Departments. The meeting also benefited from the participation of staff from PAHO/WHO Representative Offices and from WHO headquarters.

Methods of Work

5. Participants in the meeting were reminded that the Consultation was part of a global formal consultative process, mandated by and extending to the PAHO and WHO Governing Bodies. Therefore, in order to consolidate and further formalize countries' positions on the matters discussed, it was critical that they convey their feedback about the meeting to the respective Delegations due to attend the 29th Pan American Sanitary Conference/69th Session of the Regional Committee of WHO for the Americas.

6. The work methodology adopted for the meeting primarily revolved around facilitated working group discussions guided by common sets of questions (25 questions in total, Annex E), with feedback provided in plenary sessions. Simultaneous interpretation in the four official PAHO languages was provided in the plenary sessions and during selected working group sessions. The Agenda of the meeting is presented in Annex D.

7. The Consultation represented the third round of global formal consultations with WHO Member States, through the respective WHO Regional Committees, that have taken place since 2015 and that were primarily triggered by the need to collegially deliberate on issues related to the monitoring and evaluation of the IHR.

- a) The Formal Consultation in 2015 (hereafter referred to as "2015 Consultation") was held pursuant to Resolution WHA68.5² and focused on the *Concept Note - Development, monitoring and evaluation of functional core capacity for implementing the International Health Regulations (2005)*³, constituting the first version of the IHR MEF. Activities at regional level, in preparation for the 54th Directing Council/67th Session of the Regional Committee of WHO for the Americas, Washington, D.C., United States, 28 September-2 October 2015, were conducted virtually;
- b) The Formal Consultation in 2016 (hereafter referred to as "2016 Consultation") was held pursuant to Decision WHA69(14)⁴ and focused on the *Draft WHO Global Implementation Plan for the Recommendations of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response*, which, by extensively addressing monitoring and evaluation aspects of the Regulations, was closely related to the revised version of the IHR MEF presented to the Sixty-ninth World Health Assembly in May 2016 as an annex to Document A69/20⁵. Contrary to the roadmap set in its first version, the IHR MEF was only

² World Health Organization. The recommendations of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation [Internet]. 68th World Health Assembly; 2015 May 18-26; Geneva. Geneva: WHO; 2015 (Resolution WHA68.5) [cited 2017 August 15]. Available from: http://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_R5-en.pdf.

³ World Health Organization. Concept Note - Development, monitoring and evaluation of functional core capacity for implementing the International Health Regulations (2005). WHO; 2015 (?), [cited 2017 August 15]. Available from: http://www.who.int/entity/ihr/publications/concept_note_201407.pdf?ua=1.

⁴ World Health Organization. Implementation of the International Health Regulations (2005) [Internet]. 69th World Health Assembly; 2016 May 23-28; Geneva. Geneva: WHO; 2016 (Decision WHA69[14]) [cited 2017 August 15]. Available from: http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_DIV3-en.pdf.

⁵ World Health Organization. Implementation of the International Health Regulations (2005): Annual report on the implementation of the International Health Regulations (2005) [Internet]. 69th World Health Assembly; 2016 May 23-28; Geneva. Geneva: WHO; 2016 (Document A69/20) [cited 2017 August 15]. Available from: http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_20-en.pdf.

“noted” by the Sixty-ninth World Health Assembly, as no further action by the Assembly was requested. Activities at regional level, in preparation for the 55th Directing Council/68th Session of the Regional Committee of WHO for the Americas, Washington D.C., United States, 26-30 September 2016, included the face-to-face Formal Regional Consultation on the *Draft WHO Global Implementation Plan for the Recommendations of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response*, Miami, FL, United States, 1-3 August 2016⁶. The outcomes of that meeting were welcomed by the 55th Directing Council/68th Session of the Regional Committee of WHO for the Americas through Decision CD55(D5)⁷;

- c) The Formal Consultation in 2017, held pursuant to Decision WHA70(11), focused on the Draft GSP, currently embedding the IHR MEF. It has to be noted that, according to Document EB140/14⁸, presented to the 140th WHO Executive Board in January 2017, the IHR MEF should have been presented for consideration and adoption by the Seventieth World Health Assembly in May 2017. The version of the Draft GSP considered during the meeting was dated 3 July 2017 (Annex A, *Five-year Global Strategic Plan to improve public health preparedness and response - Consultation with Member States*). The final version of this document, dated 1 August 2017 and due to be presented to the WHO Regional Committees in 2017, is enclosed in Annex B, *Development of a draft five-year global strategic plan to improve public health preparedness and response - Consultation with Member States*. Participants in the meeting were informed about the major upcoming changes to the document, hence related issues were not addressed during the meeting. The IHR MEF presented in Document A69/20 was the basis for the discussions during the meeting.

Structure of the Report

8. This report was compiled on the basis of notes taken during plenary and working group sessions by dedicated PASB’s staff.

9. The report is structured around the following sections, broadly reflecting the topics addressed during the working group sessions:

- a) Scope of the Draft Five-year Global Strategic Plan;
- b) Strategic pillar 1 of the Draft GSP - Building and maintaining State Parties Core Capacities;
- c) Strategic pillar 2 of the Draft GSP - Event management and compliance;
- d) Strategic pillar 3 of the Draft GSP - Measuring progress and accountability, with focus on the IHR MEF;

⁶ Pan American Health Organization. Implementation of the International Health Regulations (IHR) [Internet]. 55th Directing Council of PAHO, 68th Session of the Regional Committee of WHO for the Americas; 2016 Sept 26-30; Washington, DC. Washington, DC: PAHO; 2016 (Document CD55/12, Rev. 1) [cited 2017 August 15]. Available from: http://www.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=36151&Itemid=270&lang=en.

⁷ Pan American Health Organization. Implementation of the International Health Regulations (IHR) [Internet]. 55th Directing Council of PAHO, 68th Session of the Regional Committee of WHO for the Americas; 2016 Sept 26-30; Washington, DC. Washington, DC: PAHO; 2016 (Decision CD55[D5]) [cited 2017 August 15]. Available from: http://www.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=37218&Itemid=270&lang=en.

⁸ World Health Organization. Implementation of the International Health Regulations (2005) - Draft global implementation plan [Internet]. 140th Session of the Executive Board; 2017 Jan 23-Feb 1; Geneva (Switzerland). Geneva: WHO; 2017 (Document EB140/14) [cited 2017 August 22]. Available from: http://apps.who.int/gb/ebwha/pdf_files/EB140/B140_14-en.pdf.

e) Conclusions.

10. Bearing in mind the objectives of the meeting, for each of the sessions, where applicable, the following is captured:

- a) Consistency with and reiteration of the position of States Parties expressed during the 2015 and 2016 Consultations;
- b) Issues around which agreement was reached, either by majority or by consensus, and that either warrant proposing actions by the PAHO and/or WHO Governing Bodies or need actions by States Parties, the WHO Secretariat, or PASB.

Scope of the Draft Five-year Global Strategic Plan

11. Participants unanimously agreed and insisted that comments and suggestions provided during the 2015 and 2016 Consultations, including those related to the IHR MEF, are still valid and that related recommendations formulated should be implemented by the WHO Secretariat.

12. As already expressed during the 2016 Consultation, the vast majority of the participants indicated that, in compliance with Article 54 of the IHR, the IHR MEF should be presented as a stand-alone document for consideration and adoption by the World Health Assembly. Therefore, two separate independent documents – the Draft GSP and the IHR MEF – should be presented for consideration and adoption by the Seventy-first World Health Assembly, May 2018, through the 142nd WHO Executive Board, January 2018.

13. While reiterating that separate courses of the two above-mentioned documents vis-à-vis the WHO Governing Bodies would constitute the most transparent way to proceed because of both legal and practical reasons – including the facts that the Draft GSP is time-limited by definition and its scope is of pertinence to the WHO Secretariat, whereas, in its current form, the IHR MEF is of pertinence to the States Parties – any potential relation, of any nature, between the two documents should be made explicit in the Draft GSP. This consideration might also warrant the revision of its guiding principle, *Linking the 5-year global strategic plan with requirements under the IHR (2005)*.

14. With respect to the possible introduction of reporting requirements at the international level for States Parties in relation to the Draft GSP, participants reiterated the position already expressed during the 2016 Consultation that “requirements that States Parties report on the status of implementation and application of the IHR will only be bound to the rollout of the prospective IHR Monitoring and Evaluation Framework.” Such position is justified by the facts that IHR provisions are much broader than the scope of the Draft GSP and that the Draft GSP and the IHR MEF are of pertinence to different entities – the WHO Secretariat and States Parties, respectively.

15. Welcoming the fact that the Draft GSP is being shaped in a participatory manner as requested by States Parties in the Americas during the 2016 Consultation, participants repeatedly pointed out that the inputs provided over time to inform the development of the Draft GSP were not taken into account by the WHO Secretariat and that these inputs are still valid. The following overarching comments were offered to shape future iterations of the document in the context of the ongoing consultative process.

- a) The Draft GSP, in spite of its title, is lacking a broad perspective, being more operational rather than strategic in nature. In fact, it mirrors the actions and deliverables of the WHO Health Emergencies Programme at the global level, presented in Document A70/7 - *Proposed programme budget 2018–2019*⁹ and adopted by the Seventieth World Health Assembly, May 2017, through Resolution WHA70.5¹⁰. Additionally, its content predominantly reiterates the commitment of the WHO Secretariat to apply and comply with IHR provisions. Therefore, pursuant to Decision WHA70(14), to be true to its title and guiding principles, the Draft GSP should be reshaped reflecting an aspirational yet realistic long-term global vision that spans across development and economy, explicitly recognizes the heterogeneity of the national and regional contexts, and builds on existing information about countries and regional priorities, without aiming to represent an aggregation of national or regional plans;
- b) The titles of strategic pillar 2, Event management and compliance, and strategic pillar 3, Measuring progress and accountability, are not entirely related to their respective contents and therefore are semantically and technically misleading. The specifics encompassed in the terms accountability, monitoring and evaluation of the application and implementation of the IHR, and monitoring of compliance with the IHR do not emerge from the text. Additionally, the text is evocative of a historical, conceptually compartmentalized approach to the IHR. In fact, demonstration of accountability exclusively falls upon States Parties; only the subset of provisions related to core capacities detailed in Annex 1 of the IHR is encompassed by the IHR MEF; and the prospective monitoring of compliance with IHR provisions is restricted to States Parties' obligations under Article 43 of the IHR (see also paragraphs 59. a) and d); and 67. b));
- c) The Draft GSP should include criteria used to set priorities, milestones, timelines, and budget and to outline monitoring and evaluation mechanisms that would apply to the WHO Secretariat at the global level;
- d) The Draft GSP should present the mechanisms through which it articulates with the WHO Health Emergencies Programme Results Framework and Budget Requirements 2016–2017¹¹; with the adopted programme budget 2018–2019 and WHO's planning cycles in general; with existing related global plans (e.g., for antimicrobial resistance); and, considering the guiding principle *Broad partnerships*, with other relevant international agendas and organizations (e.g., International Atomic Energy Agency (IAEA), World Organization for Animal Health (OIE), etc.) in order to model intersectoral coordination by concrete example (see also paragraph 41. h));
- e) The Draft GSP, of pertinence to the WHO Secretariat and because of its strategic nature, should not aim at representing an aggregation of regional, subregional, and national plans.

⁹ World Health Organization Proposed programme budget 2018–2019 [Internet]. 70th World Health Assembly; 2017 May 22–31; Geneva. Geneva: WHO; 2017 (Document WHA70/7) [cited 2017 August 22]. Available from: http://apps.who.int/gb/ebwha/pdf_files/WHA70/A70_7-en.pdf.

¹⁰ World Health Organization Programme budget 2018–2019 [Internet]. 70th World Health Assembly; 2017 May 22–31; Geneva. Geneva: WHO; 2017 (Resolution WHA70.5) [cited 2017 August 22]. Available from: http://apps.who.int/gb/ebwha/pdf_files/WHA70/A70_R5-en.pdf.

¹¹ World Health Organization. WHO Health Emergencies Programme Results Framework and Budget Requirements 2016–2017. WHO; 2016, [cited 2017 August 15]. Available from: http://www.who.int/about/who_reform/emergency-capacities/emergency-programme-framework-budget.pdf?ua=1.

16. With respect to the guiding principle *Focus on fragile contexts*, while it was reiterated that the WHO Secretariat should cater to the needs of all States Parties according to the priorities they set, it cannot be inferred from the Draft GSP how the WHO Secretariat's prospective global strategic approach to capacity building in fragile contexts would differ from that in other contexts.

17. While participants concurred that prioritizing countries to receive support from the WHO Secretariat is in keeping with one of the principles underpinning the IHR – the global public health community is as strong as its weakest link – as already expressed by States Parties during the 2016 Consultation, there was consensus that the Draft GSP is still lacking:

- a) A definition of fragile context;
- b) A description of the methodological approach to characterize fragile contexts: Participants suggested that the characterization of fragility should take into account multidimensional criteria (e.g., political, social, economic, environmental, points of entry, conflicts);
- c) A description of the process linking the determination of fragile contexts to the determination of priority countries: Participants offered diverse suggestions, ranging from national authorities conducting a Strengths-Weaknesses-Opportunities-Threats (SWOT) analysis and communicating the outcome to the WHO Secretariat, to the use of existing information that has become available to the WHO Secretariat through IHR related evaluations, health systems evaluations, and Sustainable Development Goals (SDGs)-related activities;
- d) The timeframe according to which a country would be regarded as a priority one and the timing of assessment/reassessment of countries' context. Participants indicated that countries not included in the global priority countries list might experience a diversion of resources and focus from areas of work relevant to ensure compliance with IHR provisions.

18. Participants indicated that national authorities in the Americas are generally aware of the weaknesses and needs of their respective countries, as well as of the fact that only the institutionalization of national capacities can ensure sustainability. This is regarded as sufficient to constitute the basis to shape multi- and/or bilateral technical cooperation initiatives. Additionally, common needs across the Region were identified, including strengthening the capacity to prepare for and respond to acute public health events related to chemical- or radiation-related hazards and strengthening human resources.

19. In order to achieve balance and equity in the distribution of resources among countries in the Americas, it was suggested that regional and subregional mechanisms should be strengthened.

20. The majority of the participants did not regard as necessary the development of a stand-alone Five-year Regional Operational Plan, separate from the PAHO Biennial Work Plans (BWPs, 2018-2019 and beyond), and considered current PAHO planning and delivery mechanisms for technical cooperation sufficient to accommodate and absorb countries' needs.

21. It was noted that the PAHO BWP 2018-2019¹² will be presented for consideration and adoption by the 29th Pan American Sanitary Conference/69th WHO Regional Committee for the Region of the Americas, and that it addresses the elements needed to support application of, implementation of, and compliance with the IHR, including those related to monitoring and evaluation.

22. Similarly, it was noted that PAHO Members States and PASB engaged in the strategic and political process of developing *The Sustainable Health Agenda for the Americas 2018-2030*¹³. This document, which will be presented for consideration and adoption by the 29th Pan American Sanitary Conference/69th WHO Regional Committee for the Region of the Americas, comprehensively encompasses application of, implementation of, and compliance with the IHR under the section “Goal 8: Strengthen national and regional capacities to prepare for, prevent, detect, monitor, and respond to disease outbreaks, emergencies, and disasters.”

23. However, it was pointed out that Country Cooperation Strategies (CCS)^{14,15}, which should constitute the basis for elaborating the PAHO BWPs, are often exclusively negotiated by national authorities at political and intermediate levels without the input of the technical level. Therefore, it was suggested that CCS should, by default, refer to the Regulations, so that related priorities are duly represented.

24. Similarly, as already indicated during the 2016 Consultation, it was pointed out that the volume of countries’ related information available to the WHO Secretariat and PASB has the potential to be better used to inform country technical cooperation activities.

Strategic pillar 1 - Building and maintaining State Parties Core Capacities

25. With reference to the guiding principle *Integration with health systems*, as already expressed during the 2016 Consultation, participants reiterated that the Draft GSP should:

- a) Present a conceptual framework bridging core capacities detailed in Annex 1 of the IHR as essential public health functions (EPHFs);
- b) Be explicit on the strategies envisaged to promote and trigger the shift from core capacities to EPHFs while maintaining sufficient political awareness regarding States Parties’ rights and obligations vis-à-vis the international community under IHR provisions.

26. Similarly, as already expressed during the 2016 Consultation, participants reiterated that the Draft GSP should reflect the wide variation across States Parties with respect to both the maturity of their health systems and the status of their application and implementation of the IHR. This would help ensure that individual States Parties adopt the most appropriate model for sustaining core capacities in their health system’s context and, hence, for strengthening existing national planning approaches beyond a “dedicated national IHR plan.”

¹² Pan American Health Organization. PAHO Program and Budget 2018-2019. Official document to be presented to the 29th Pan American Sanitary Conference (Document CSP29/OD354) [cited 2017 August 15]. Available from: http://www.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=41697&Itemid=270&lang=en.

¹³ Pan American Health Organization. Sustainable Health Agenda for the Americas 2018-2030. Working document to be presented to the 29th Pan American Sanitary Conference (Document CSP29/6) [cited 2017 August 15].

¹⁴ Pan American Health Organization. Country Cooperation Strategies. PAHO, [cited 2017 August 15]. Available from: http://www.paho.org/hq/index.php?option=com_content&view=article&id=2126&Itemid=1849.

¹⁵ World Health Organization. Country Cooperation Strategies. WHO, [cited 2017 August 15]. Available from: <http://who.int/country-cooperation/what-who-does/strategies-and-briefs/en/>.

27. Participants regarded the dimensions of stewardship and governance of the strategy for universal access to health and universal health coverage as critical to establishing and sustaining operational core capacities. Robust stewardship and governance dimensions not only entail the existence of efficient legal, planning, and financing frameworks for EPHFs, but would also be conducive to creation of opportunities to raise and/or maintain a high level of awareness about the IHR at political levels. Therefore, within the context of health systems strengthening, activities aimed at consolidating the exercise of stewardship and governance should be prioritized.

28. It was recognized that the ability of States Parties to sustain core capacities is dependent upon:

- a) The understanding, among national authorities, that the IHR are not a new technical discipline, but rather a tool to support the continuous strengthening of EPHFs, mostly already in existence and, to different extents, already operational within the health system. By extension, this enables States Parties to apply and comply with the Regulations, as well as to contribute to global public health;
- b) Efficient national planning, where, ideally, resources for planning are identified in advance, mechanisms for articulating the plans across different sectors are in place, and monitoring and evaluation mechanisms are present;
- c) Efficient national resource allocation mechanisms. It was recognized that, at present, national financial resources are considered to be scarce and that the allocation of funds to respond to health-related emergencies, emergencies of any kind, or new political priorities is currently diverting programmatic funds allotted, broadly speaking, to public health.

With reference to points *a)*, *b)*, and *c)*, the following suggestions were offered as options to ensure the sustainability of core capacities detailed in Annex 1 of the IHR:

- i. The use of social marketing techniques to advocate to decision makers and politicians should be explored, with focus on:
 - Emphasizing the preventive aspects deriving from application of and compliance with the IHR, which would minimize the negative economic consequences of acute public health events on international tourisms and trade; acquiring the ability to demonstrate the costs of responses to acute public health events; performing cost-effectiveness analysis for elaborating case studies regarding the management of acute public health events to be presented to decision makers in order to enable better allocation and management of financial resources before the occurrence acute public health events; communicating to decision makers that the absence of acute public health events represents a success derived from capital investments and sustained allocation of financial resources for programmatic purposes and, hence, that reduction or discontinuation in funding would not be justified;
 - Demonstrating the existing commonalities and synergies between international commitments that countries have signed up for (IHR, SDGs, Sendai Framework for Disaster Risk Reduction); the degree to which existing national actions and interventions are already fulfilling them, without the need to create new institutional structures; and the need to ensure that resources are made

available and, possibly, increased to allow fulfillment of those commitments and international obligations;

- ii. The accurate representation of core capacities in the programmatic budgeting process would allow adequate funds to not only be assigned but also earmarked. To this effect, personnel from the planning departments of the Ministries of Health, together with other departments with responsibilities related to application of and compliance with IHR provisions, should simultaneously be involved in the planning process;
 - iii. Existing non-programmatic planning and budgeting processes, such as those related to risk management and to the national emergency system, could be better used for programmatic purposes;
 - iv. Efforts at the national level are warranted to identify financial resources within the country, beyond the health sector and beyond the public sector;
 - v. Mechanisms should be established to ensure accountability and transparency so that, in spite of government and authority turnover, the chance for continuity in the allocation of financial resources can be enhanced by demonstrating the correlation between promises and results achieved.
- d) A national legal framework consistent with IHR provisions and encompassing all institutions across sectors with responsibilities vis-à-vis the application of and compliance with the Regulations. Despite 10 years having elapsed since the entry into force of the IHR, States Parties are still facing substantial challenges in adjusting their national legal framework, and this is regarded as significantly hindering their ability to sustain core capacities;
 - e) The engagement with local authorities across administrative levels and sectors. The sustainability of capacities at the local level is regarded to be deeply entwined with the availability of health professionals in adequate number and with adequate skills. The federal system of some States Parties in the Americas is regarded as a factor that might hinder the sustainability of core capacities;
 - f) Mechanisms for fostering and maintaining intersectoral interactions (see also paragraph 33).

29. The presentation of the conceptual framework bridging core capacities and EPHFs in the Draft GSP would enable the health sector:

- a) To streamline and make more coherent and efficient its internal planning and resource allocation processes;
- b) To operationalize core capacities, especially at the subnational level, including in federal states;
- c) To engage with other sectors, hence broadening the sense of ownership of the IHR and promoting the concept that the IHR do not constitute a discipline per se or an end to themselves.

30. With reference to the guiding principles *Country ownership* and *Integration with health systems*, and underlining the expected benefits that the clear framing of core capacities detailed in Annex 1 of the IHR as EPHFs would have in terms of enhancing States Parties' ability to apply and comply with IHR provisions, participants emphasized their commitment

towards the IHR as a State's affair, with its primary *raison d'être* rooted in robust national institutions to guarantee sustainability.

31. Participants expressed concerns regarding the possibility that the WHO Secretariat and/or PASB might introduce the application of different metrics for measuring the status of core capacities detailed in Annex 1 of the IHR and EPHFs and called for the WHO Secretariat and PASB to give the utmost level of consideration to this aspect. PASB indicated that work is ongoing to move from quantitative metrics applied to EPHFs to a qualitative approach aimed at stimulating the transformation of the health systems toward universal access to health and universal health coverage.

32. With reference to the guiding principle *Intersectoral approach*, the following challenges related to the identification and activation of intersectoral mechanisms were identified:

- a) Uneven sense of ownership of the IHR across sectors;
- b) Limited awareness and recognition of the mutual benefits of joint intersectoral planning and interventions;
- c) Limited opportunities to identify areas of common interest across sectors and that might lead to the identification of synergies;
- d) Lack of integrated planning and budgeting mechanisms to make synergic use of resources available, as well as of mechanisms for joint mobilization of resources;
- e) Lack of budget for all sectors to fulfil their responsibilities with respect to the application and implementation of IHR provisions of their competence;
- f) Existence of competing priorities within the different sectors in the context of shortage of human and financial resources.

33. In order to overcome challenges related to both programmatic and emergency management aspects of intersectoral interactions, the following suggestions were offered:

- a) Proactive and systematic awareness-raising activities should be carried out and should target the political and decision-making levels across sectors before crises strike (e.g., holding periodic meetings engaging the political level across sectors);
- b) Extensively and comprehensively identify governmental institutions with direct or indirect responsibilities related to the establishment and maintenance of the core capacities, including the characterization of their respective resources, both financial and non-financial;
- c) Involve sectors other than health in the elaboration of major strategic and programmatic documents of the Ministry of Health, as well as in its periodic planning and budgeting activities in order to make synergic use of resources available and, possibly, to mobilize additional ones;
- d) Effectively communicate public health activities and achievements across sectors in order to maintain heightened awareness and to support resource mobilization efforts. In particular, efforts are warranted to advocate to ministries of finance about the financial value-added of public health and to the tourism industry about the potential economic consequences of not applying, implementing, and complying with the IHR;

- e) By virtue of their privileged perspective on international health, as well as their relations with international organizations, ministries of foreign affairs could be effective brokers of national intersectoral mechanisms related to application of, implementation of, and compliance with the Regulations, including for joint intersectoral planning at the national level;
- f) Establish ex novo or activate an existing intersectoral institutional body tasked, inter alia, with monitoring the status of core capacities, taking into account the implementation of relevant institutional plans across sectors, through the use of indicators generated by the respective monitoring and evaluation institutional mechanisms and with the power to take corrective actions;
- g) Collegially undertake an annual intersectoral exercise to comply with IHR provisions related to reporting at the international level on the status of implementation of the Regulations, by completing the State Party Annual Report to be submitted to the World Health Assembly or through participation in other voluntary exercises outlined in the IHR MEF, such as after-action reviews, simulation exercises, and joint external evaluations. The above-mentioned exercises could also constitute an opportunity to engage with the political level across sectors;
- h) Strengthen risk communication mechanisms across the Region in order to enable the activation of intersectoral mechanisms.

34. While it was noted that, in some States Parties in the Region, PASB's technical, financial, and advocacy support has been instrumental for the establishment and maintenance of core capacities and that this support should be maintained in the future, participants indicated that PASB's technical cooperation activities should:

- a) Expand to technical areas traditionally associated with health systems' expertise in order to facilitate the involvement of national authorities in charge of health services in the public health planning process;
- b) Focus on the elaboration of strategic plans to ensure the sustainability of an adequate health workforce;
- c) Facilitate the bridging of political divergences across sectors, including at the subnational level;
- d) Focus on the development of an information note outlining models and mechanisms to facilitate intersectoral collaboration at the national level, as such a document would also serve advocacy purposes;
- e) Share with States Parties more granular information received through the submission of the IHR States Parties Annual Reports to the World Health Assembly in order to stimulate the intersectoral planning process at the national level and exchanges of good practices among States Parties, as well as to catalyze bilateral or multi-country cooperation initiatives (see also paragraphs 77; and 39. c. ii));
- f) Promote exchange of information and good practices among States Parties and facilitate networking for capacity building purposes among States Parties as well as access to partners;
- g) Advocate for the benefits of intersectoral collaboration vis-à-vis:
 - i. Other international organizations, such as the World Trade Organization (WTO), by ensuring that they have a clear understanding of the objectives and

multisectoral scope of the Regulations, and by inviting them to engage with their respective counterparts at the national level on the basis of IHR provisions;

- ii. Subregional economic integration mechanisms, by ensuring that the IHR constitute a permanent item on the agenda of these fora at the highest level.

Strategic pillar 2 - Event management and compliance

National IHR Focal Point

35. During the meeting, PASB repeatedly stressed that, at the national level, the three components that makes the institutional ground conducive for applying, implementing, and complying with the Regulations are:

- a) Sustained political support;
- b) Coordination and oversight by an institutional entity with intersectoral convening power, access to decision makers across sectors, and comprehensive knowledge and understanding of States Parties' rights and obligations under the IHR and other related international agreements;
- c) Operational arrangements, such as those related to the National IHR Focal Point (NFP) and to the management of acute public health events.

53. The functions of the NFP of an exclusively operational communication nature fall under the latter category and, to that effect, PASB stressed that the exercise of the NFP's functions by the designated institutional entity, unless justified on the basis of thorough institutional and operational analyses, does **not** include:

- a) Creating an ad hoc institutional entity;
- b) Coordinating and overseeing application of, implementation of, and compliance with the IHR;
- c) Performing public health surveillance functions;
- d) Ensuring the function of public health early warnings, but rather being at the receiving end of the signals generated by different surveillance systems, including event-based ones across sectors;
- e) Carrying out acute public health event-related risk assessment;
- f) Applying the decision instrument in Annex 2 of the IHR in order to engage with WHO, through the IHR Contact Points at the Regional Office level, for acute public health event management purposes;
- g) Coordinating response operations;
- h) Assigning a dedicated physical space to carry out the NFP's functions.

36. Despite Article 4 of the Regulations being one of the very few IHR provisions that clearly mandate the attribution of institutional functions, participants reiterated the challenges States Parties continuously face in exerting the NFP functions.

37. While the NFP functions in 33 out of 35 States Parties in the Americas are exerted by an institutional entity directly in charge of or closely related to communicable disease epidemiology, as already highlighted during the 2016 Consultation, it was recognized that the NFP's governance, institutional positioning, and operational structure, supported by an appropriate legal status and assignment of functions, vary greatly across countries within and beyond the Region – from one individual with multiple responsibilities that include ensuring the 24/7 functions for the NFP, to an institutional unit with a dedicated physical space and dedicated staff. It was also recognized that the consolidation of the NFP's functions requires striking a fine balance with respect to the NFP's institutional positioning, including considerations about whether and to what extent to prioritize institutional connectivity over technical expertise and also considering the size and administrative structure of the country. Similarly, there was agreement about the fact that while a high institutional position for the NFP may facilitate its access to the decision-making level, it may also jeopardize continuity and operational communication by exposing the NFP to political influence and political changes.

38. Over the past 10 years, the NFPs have reported facing the same challenges in terms of governance, possibly signaling the need for a thorough review of the institutional positioning and functioning of the NFPs in the Region. These challenges were further elaborated upon during the meeting and are enumerated in the paragraphs following:

- a) The mandatory functions of the NFP detailed in Article 4 of the IHR were reported not to be clearly understood in all States Parties, especially at the highest institutional level. Therefore, even though in States Parties that are small in size the NFP and IHR coordination and oversight functions are, by default, generally ensured by the same institutional entity, the need persists for the WHO Secretariat and PASB to clarify the mandatory NFP functions;
- b) The need for the NFP to have the political backup to be strategically positioned at institutional level – in order to have intersectoral leverage – , and yet to maintain technical independence while exchanging information in compliance with established institutional clearance mechanisms, is not paralleled by the desired level of awareness, knowledge, and understanding at higher hierarchical levels, including the political one;
- c) The persistent inadequacies of the national legal framework in relation to NFP functions constitute an additional obstacle to their efficient and effective delivery;
- d) Lack of clarity regarding the scope of the mandatory functions of the NFP poses challenges with regard to determining an adequate budget allocation. It was pointed out that, from a prevention perspective, adequate investments and sustained resource allocation to strengthen and maintain core capacities detailed in Annex 1 of the IHR would be likely to reduce the budget dedicated to the delivery of the NFP functions;
- e) It is still not clear at the national level that the NFP functions that must be available on a 24/7 basis cannot be delivered by one single official and that they need to be shared by pool of officials with access to the necessary means of communication. To that effect, it was suggested that the IHR MEF should enable the identification of States Parties where NFP functions are handled by a single professional;
- f) Staffing of the 24/7 NFP functions remains challenging for multiple reasons, including actual shortage of human resources, officials having multiple responsibilities in addition to covering the NFP functions, absence of legal and contractual arrangements

providing for 24/7 services, and inadequate level of training of officials exercising the NFP functions due to transition and turnover of personnel;

- g) Adequate means of communication on a 24/7 basis are not always available because of the lack of access to international telephone lines, which in some cases need to be justified in the budget on an annual basis, and because of the lack of adequate internet coverage, especially in large countries. It was noted that, in some cases, NFP functions tend to be equated with the existence of a physical operation center, which can logistically facilitate communication but by no means should be regarded as a substitute for, or overlap with the functions of, an emergency operations center;
- h) Across the Region, intra- and, more conspicuously, intersectoral connectivity of the NFP is regarded as suboptimal, causing delays in communication because of:
 - i. Insufficient knowledge and awareness of the obligations of and potential implications for the State Party with respect to information exchanges with the international public health community about acute public health events;
 - ii. Lack of domestic clearance procedures for engaging and/or sharing information with both WHO, through the IHR Contact Points at the Regional Office level, and other States Parties, potentially interfering with risk and media communication activities related to any given acute public health event;
 - iii. Lack or inadequacy of procedures for information sharing, particularly in terms of early warning signals, consistent interpretation of the information, and complexity of the numerous institutional layers to be connected, especially in federal countries or for countries with overseas territories;
- i) During a domestic emergency or Public Health Emergency of International Concern (PHEIC), the capacity to scale up the NFP functions is either lacking or inadequate. Similarly, procedures to institutionally migrate the NFP functions temporarily in the context of an activated national emergency management structure, all the while ensuring that matters unrelated to the emergency continue to be dealt with, are either lacking or insufficient. In the absence of procedures, the interactions between the NFP and response teams remain challenging (see also paragraph 53);
- j) The NFP network is neither optimally harnessed nor totally efficient for horizontal communication between States Parties;
- k) Although PASB's support to strengthen the NFP and heighten awareness about its functions was appreciated, the advice provided was perceived as prescriptive and not always consistent with national laws and regulations.

39. In addition to the comments and suggestions expressed during the 2016 Consultation, participants reiterated the needs for the Draft GSP:

- a) To present the NFP functions, together with the minimum legal, budgetary, human resources, and operational requirements that would be conducive for their sustainability;
- b) To outline the strategies that the WHO Secretariat intends to adopt to raise political awareness at the national level in order to strengthen the positioning of the NFP in the context of intersectoral arrangements for the management of acute public health events;
- c) To outline strategies to enhance mechanisms for States Parties to exercise peer-pressure, to foster trust building among States Parties, to enhance country ownership,

and to stimulate bilateral capacity building efforts among States Parties. To this effect, the following suggestions were made:

- i. Mechanisms to strengthen horizontal communication and information sharing among NFP;
 - ii. Establishment of a virtual Community of Practice for NFPs (e.g., sharing of good practices and lessons learned in terms of domestic coordination). Although it would be highly desirable for the Community of Practice to be global, participants indicated that the Americas should pilot this approach (see also paragraphs 34.e) and f)).
- d) To explicitly include the updating of the WHO document *National IHR Focal Point Guide*¹⁶ and its broadening to encompass the functioning of the NFP during emergencies;
- e) To outline the process for the prioritization and elaboration of technical guidance documents that the WHO Secretariat intends to develop. This is needed because during the 2016 Consultation States Parties in the Americas indicated that, given the broad variation in capacities between WHO Regions, any guidance document by the WHO Secretariat should be produced at the regional level to ensure that the contents are appropriate for the context, hence preventing setbacks in WHO Regions and States Parties where NFP capacity is already well established and their functions well understood;
- f) To outline the strategic approach to training that is needed to target different audiences (e.g., national officials ensuring the 24/7 NFP functions, officials at subnational levels, staff of the WHO Secretariat at Country Office level), and to specifically indicate what use will be made of the *OpenWHO web-based, knowledge-transfer platform for improving the response to health emergencies*¹⁷ as well as the *WHO Health Security learning Platform in the context of the IHR*¹⁸.

40. Participants recognized that the support provided by PASB over the years to strengthen the NFPs' functions goes beyond the current scope of the Draft GSP. It was suggested that ongoing technical cooperation activities be continued by PASB, and proposals for expanding them were provided. These include:

- a) Maintaining heightened awareness among national authorities at the highest level, and across sectors, about NFP functions and the need to allocate adequate resources;
- b) Supporting the NFPs in fulfilling their mandatory functions by:
 - i. Providing training to officials tasked to carry out NFP duties as well as government officials who are part of NFP-related information sharing paths. Along with the limited sustainability of epidemiology training activities at the subnational level in particular, it was also pointed out that epidemiology training programs do not necessarily address the functions and functioning of the NFP;
 - ii. Reviewing the NFP's national procedures. Despite having emphasized the diversity of the institutional contexts in which NFPs are operating across the

¹⁶ World Health Organization. National IHR Focal Point Guide. WHO; 2009 (?), [cited 2017 August 15]. Available from: <http://www.who.int/ihr/English2.pdf>.

¹⁷ World Health Organization. OpenWHO web-based, knowledge-transfer platform for improving the response to health emergencies. WHO, [cited 2017 August 15]. Available from: <https://openwho.org/courses>.

¹⁸ World Health Organization. WHO Health Security learning Platform in the context of the IHR. WHO, [cited 2017 August 15]. Available from: <https://extranet.who.int/hslp/training/>.

Region, some participants suggested that NFP operating procedures should be standardized within and beyond the Region;

- iii. Supporting exchange of experiences among peers through technical visits;
- iv. Encouraging peer-to-peer exchange of information and good practices among NFPs;
- c) Organizing annual regional NFP meetings to build trust and as a mechanism to exercise peer pressure;
- d) Recalling that, during the 2016 Consultation, States Parties in the Region indicated that guidance documents by the WHO Secretariat should be produced at the regional level to ensure that the contents are appropriate for the context, improving PASB technical and operational guidance documents, including with regard to:
 - i. The role of the NFP in the management of acute public health events;
 - ii. The information flow between the NFP and the subnational levels;
 - iii. The information flow between all national institutions that could possibly be involved in the management of acute public health events of potential or substantiated international concern;
 - iv. The flow of information between the NFP, the PAHO/WHO Country Offices, and the WHO IHR Contact Point, hosted by PASB, since this is deemed to facilitate communication with the media;
 - v. The institutional and operational relationship between the NFP and the/an Emergency Operations Center (EOC);
 - vi. The dissemination of models implemented by States Parties, and deemed to be functional, regarding the positioning of the NFP in the context of intersectoral arrangements for the management of acute public health events;
- g) While it was noted that the information flow between States Parties and the WHO IHR Contact Point needs to be improved, the Region of the Americas as a pathfinder should explore the use of more innovative means for communication related to acute public health events, such as WhatsApp.

Management of acute public health events

41. No strategic approach related to the management of acute public health events is presented in the Draft GSP. It only reiterates the commitment of the WHO Secretariat to apply and comply with relevant IHR provisions and refers to an operational tool – the web-based Epidemic Intelligence from Open Sources (EIOS) platform. Therefore, for it to acquire the desired strategic breadth, relevant comments and suggestions, including those already expressed during the 2016 Consultation, are offered in the following paragraphs. The Draft GSP should:

- a) Ensure that the strategic focus is on how the WHO Secretariat intends to deliver technical cooperation to strengthen States Parties and not exclusively on the strengthening of WHO Secretariat itself;
- b) Ensure that the strategic focus related to the management of acute public health events is presented in the context of the sustainable allocation of resources to strengthen and maintain national core capacities, which should constitute the strategic priority of the Draft GSP, as a prerequisite for the management of acute public health events;

- c) Address the risk assessment process related to acute public health events as a shared responsibility of States Parties and the WHO Secretariat;
- d) Provide indications about how the risk assessment process, which is continuous and reiterative, will be strengthened as a result of a bottom-up approach and provide evidence supporting this approach;
- e) Provide strategic indications on how the WHO Secretariat intends to improve transparency in relation to the formulation of temporary recommendations when a PHEIC is determined; to the monitoring of their application and implementation; and to their discontinuation;
- f) Provide indications on how WHO intends to improve acute public health events-related communication across the three organizational levels of the WHO Secretariat;
- g) Set forth strategies for routinely advocating for the need for transparency at the political level, considering that, within rapidly changing national political landscapes, States Parties may not be prone to disclose information;
- h) As already highlighted under paragraph 15. d), provide indications on how the WHO Secretariat intends to model intersectoral coordination by concrete example.

42. In order to inform the revision of the Draft GSP, participants offered additional considerations, both general and specific to the different but overlapping phases inherent to the management of acute public health events.

43. Notwithstanding that the purpose and scope of the IHR focus on the management of acute public health events that might have international public health implications, and that other international complementary frameworks are in force for disaster management, participants called for a broader and consistent application of IHR provisions to events such as the current protracted migration crisis that are not acute *sensu stricto*.

44. Intra- and intersectoral coordination among national institutions involved in the management of acute public health events emerged as the major bottleneck experienced at the national level throughout the acute public health events management process. Challenges and suggestions on how to overcome them are enumerated below:

- a) There is little knowledge at the national level about the reporting obligations for acute public health events or risks at the international level that are pertinent to different national institutions. Knowledge related to the communication channels used is equally limited. Therefore, it was suggested that:
 - i. The WHO Secretariat compile, maintain up to date, and publish on the secure WHO Event Information Site (EIS) the lists of national focal points (or equivalents) with international reporting obligations vis-à-vis other international organizations (e.g., IAEA, OIE, International Network of Food Safety Authorities [INFOSAN]);
 - ii. The NFP also compile and maintain up to date the list of national institutions with international reporting obligations;
 - iii. Any report at the international level made by any national institutions in compliance with their international reporting obligations be systematically shared among the focal points (or equivalent) at the national level;

- iv. Relevant officials, operating across sectors at the national level, undergo joint training sessions.
- b) There is a need for national authorities to coordinate across sectors the compilation and maintenance of a roster of national subject matter experts who can be accessed for acute public health events management purposes. For those areas for which subject matter experts cannot be identified in country, PASB's input and facilitation should be sought.

45. With respect to events' detection, participants recognized the contribution of the Global Public Health Intelligence Network (GPHIN) platform. Concerns were raised regarding the detection of events related to hazards others than infectious ones (e.g., chemical and radiation-related hazards), which seem to be associated with a longer time lag between actual occurrence and detection. Similarly, concerns were raised regarding the ability to follow up on the detection of unusual health events in the context of a public health emergency, either domestic or international, when laboratory capacity might be reduced.

46. With respect to events-related risk assessment, participants tended to regard risk assessment as a one-off exercise and to directly equate risk assessment to the ability to predict the international spread of any given public health risk, disregarding that risk assessment is a continuous and reiterative process that should be contextualized according to public health interventions adopted in response to any given event.

47. While the qualitative approach to risk assessment related to events occurring within the national territory is generally regarded as satisfactory, participants expressed the need for tools allowing for a less empirical approach, as well as for the application of Annex 2.

48. It was highlighted that, while risk assessment is common practice for acute public health events occurring within the territory of any given country, for acute public health events occurring elsewhere, the risk assessment provided by the WHO Secretariat is regarded as insufficient and that States Parties need to be enabled to carry out their own risk assessment.

49. Participants indicated that, despite the joint efforts of States Parties and the WHO Secretariat to jointly perform events' related risk assessment, the conclusions reached by the parties are not always convergent. Therefore, participants would regard the publication on the secure EIS of further elaborations surrounding the risk assessment process related to any given acute public health event as a sign of increased transparency by the WHO Secretariat.

50. With respect to events-related information sharing, participants called for increased transparency by the WHO Secretariat, specifically indicating that it would be highly desirable for the WHO Secretariat to share information about acute public health events being monitored when they first come to the attention of the WHO Secretariat, regardless of the source of information.

51. Recalling that, during the 2016 Consultation, States Parties in the Americas emphasized that information on acute public health events shared by the WHO Secretariat through existing channels (e.g., EIS) should be more farsighted; better structured; be graded according to the risk, also taking into account the severity of an event; and be more explicit in terms of specific public health actions deemed appropriate for States Parties to take, participants highlighted that, especially for States Parties smaller in size, the information

posted on the EIS constitute the primary source of epidemic intelligence regarding events occurring outside their territories (see also paragraph 60. e)).

52. In spite of Article 4 of the IHR mandating the NFP to “*disseminate information to, and consolidating input from, relevant sectors of the administration of the State Party concerned, including those responsible for surveillance and reporting, points of entry, public health services, clinics and hospitals and other government departments,*” participants still expressed unfounded doubts about whether the information posted on the EIS can be shared with national counterparts. Additionally, it was pointed out that information management and sharing at national level should be improved, especially to avoid the concentration of information shared through channels established in compliance with IHR provisions to one, or a very limited number of officials.

53. In several occasions throughout the meeting, participants hinted to the fact that information exchanges among States Parties, and between States Parties and the WHO Secretariat, should be supported by interactive platforms.

With respect to the response to acute public health events, participants reiterated the need to clarify the procedures for information sharing between the NFP and response teams deployed to the field (see also paragraph 38. i)).

54. Participants indicated that they were not privy to information regarding the web-based Epidemic Intelligence from Open Sources (EIOS) platform mentioned in the Draft GSP, and included as one of the deliverables in the approved WHO “Proposed programme budget 2018–2019.”

55. It was clarified that the EIOS web-based platform was being developed by the WHO Secretariat to improve its own event management capacity, also providing the desired level of redundancy to epidemic intelligence activities performed globally; that the platform intends to integrate the event detection and risk assessment components, also allowing for its contextualization on the basis of more refined parameters; and that it focuses on infectious hazards.

56. While the EIOS web-based platform is intended to be used by the WHO Secretariat, participants indicated that, anticipating that such a platform could be of some use at national level, efforts would be warranted for its subsequent roll-out at country level, despite the inherent challenges of a global tool to cater for all the needs of any given country. Should the roll-out of the EIOS web-based platform be part of the plans of the WHO Secretariat, participants indicated that:

- a) States Parties should be given the opportunity to contribute to the design of the EIOS web-based platform in order to lay out the rules of engagement between the WHO Secretariat and States Parties and to ensure that issues of legal nature, as well as related to data security and confidentiality are duly taken into account and addressed;
- b) Reiterating the need to adopt a less empirical and more evidence-based approach to event related risk assessment, the risk assessment component of the EIOS web-based platform would be of particular interest to States Parties in the Americas. Therefore, suggestions were offered regarding attributes and functionalities of the EIOS web-based platform for it to be accepted and possibly used at national level. the EIOS web-based platform should:

- i. Be available in all WHO official languages;
- ii. Expand its scope to cover all hazards, beyond infectious ones;
- iii. Be user-friendly and linked to the EIS;
- iv. Grade risk according to the context considered;
- v. Have mapping facilities embedded;
- vi. Not require burdensome data input by the users at national level to allow customized risk assessment activities, since there are concerns that about the risk of duplicating existing surveillance activities;
- vii. Allow national authorities to grant access to the platform to users at national level as they deem appropriate, including beyond the health sector.

Additional health measures

57. Public health measures for managing an unfolding acute public health event are dynamically adjusted and adopted as a result of the continuous and reiterative risk assessment process. Therefore, it was noted with satisfaction that, as suggested during the 2016 Consultation, the Draft GSP addresses additional health measures, referred to in Article 43 of the IHR, in a holistic manner, not only encompassing those adopted in relation to a PHEIC, but under any circumstance.

58. No strategic approach related to the monitoring and management of additional health measures is presented in the Draft GSP. Therefore, for it to acquire the desired strategic breadth, comments and suggestions in this regard, including those already expressed during the 2016 Consultation, are offered in the following paragraphs.

59. Notwithstanding the sovereign rights of any given country, on the basis of challenges experienced at national level that are hampering the application of Article 43, the Draft GSP should:

- a) Present the approach to monitoring of compliance with IHR provisions in their totality. Hence, neither restrictively focusing on specific provisions, such as Article 43, nor on States Parties only (see also paragraphs 15. b); and 59. d));
- b) With ultimate goal of overcoming the asymmetric treatment of different States Parties by the WHO Secretariat, and hence improving transparency, outline steps and timeline of the consultative process with States Parties for the development of a standardized process for the monitoring and management of additional health measures, including issues related to the transparency of interactions between the WHO Secretariat and any given State Party. It has to be noted that a draft flowchart of a process for the monitoring and management of additional health measures, developed by the WHO Secretariat at headquarters level, was presented at the meeting;
- c) Provide strategic orientations on how to promote dialogue between technical areas of the different institutional entities concerned with the IHR and the political level, including the Ministry of Health's External/International Relations Office and the Ministry of Foreign Affairs, which, by definition, has privileged interactions with international organizations. To this effect, it was noted that the adoption of some public health measures might come to the attention of the World Trade Organization (WTO). However, it remains unclear how the health sector would trigger procedures

that could escalate to the WTO and how the WHO Secretariat is interacting with WTO;

- d) Explicitly address the settlement of disputes, referred to in Article 56 of the IHR, and elaborate on the WHO Secretariat's strategy to encourage the dialogue among States Parties and with the WHO Secretariat, not only in relation to the application of, and compliance with Article 43, but encompassing all IHR provisions. It was pointed out that bilateral dialogue between States Parties is implicit in both, Article 56 – *"In the event of a dispute between two or more States Parties concerning the interpretation or application of these Regulations, the States Parties concerned shall seek in the first instance to settle the dispute through negotiation or any other peaceful means of their own choice, including good offices, mediation or conciliation"* –, and Article 43 – *"Without prejudice to its rights under Article 56, any State Party impacted by a measure taken [...] may request the State Party implementing such a measure to consult with it. The purpose of such consultations is to [...] a mutually acceptable solution"* (see also paragraphs 15. b); and 59. a));
- e) Elaborate on how the WHO Secretariat would promote the exercise of health diplomacy in relation to the application of Articles 43 and 56, at different levels: bilaterally; sub-regionally and regionally, through economic integration mechanisms; multilaterally, through the WHO Secretariat. It is understood that, in the interest of consistency and transparency, this would require striking a fine balance between the rigidity of a standardized process and flexibility of health diplomacy. Similarly, it was recognized that the application of the rarely invoked Article 56 of the IHR represents a signal of a reactive approach to public health.

60. While stressing the sovereign right of any given State Party, participants reiterated challenges experienced at national level which are hampering the application of Article 43, and provided suggestions to overcome them:

- a) Existing national legislation (e.g. quarantine laws) may prevent States Parties from complying with Article 43;
- b) A State Party might be truly unprepared to manage a public health risk without putting at risk national security (e.g. States Parties that had transparently requested extensions) and is additionally exposed to undue pressure to lift measures exerted by other States Parties and/or by the WHO Secretariat;
- c) Risk perception at technical and political levels, within and between countries, might diverge as a result of a risk assessment informed by diverse criteria;
- d) Public risk perception and pressure often lead to the adoption of measures by political decision-makers, overriding scientific evidence;
- e) Both, the advice provided by the WHO Secretariat regarding public health measures posted on EIS in relation to specific acute public health events, and, in particular, Temporary Recommendations issued in relation to the determination of a PHEIC, are not presented with due scientific evidence supporting their formulation. Additionally, Temporary Recommendations not always specify the subsets of States Parties to which they apply and their rationale; they are not always elaborated thoroughly taking into consideration the feasibility of their implementation; and they do not embed mechanisms for monitoring compliance. This approach is regarded as ambiguous and, unless rectified, it is perceived as fomenting a reactive approach to the adoption of public health measures by national authorities. Participants reiterated that, as acute

public health events unfold, the use by the WHO Secretariat of a risk grading approach, signaling prevailing national, sub-regional, regional, and global public health implications, would substantially contribute to the fine tuning of public health measures adopted by national authorities; (see also paragraph 51)

- f) Recalling that there are no provisions in the Regulations mandating the WHO Secretariat to proactively conduct the monitoring of potential additional health measures using informal sources of information, and that, according to Article 43, States Parties should provide scientific evidence supporting the adoption of additional health measures, suggestions for shaping the standardized process for the monitoring and management of additional health measures include:
- i. The criteria to be applied by States Parties and by the WHO Secretariat to determine whether a measure “should” or “could” be regarded as an additional health measure should be explicit. It was noted that, the need for States Parties to improve their acute public health event related risk assessment capacity also extend to additional health measures, in particular as for their ability to accurately determine the actual or possible impact that any given measure might have on international travel and trade;
 - ii. The joint States Parties-WHO Secretariat Annual Report on the implementation of the IHR report to the World Health Assembly should present which States Parties adopted additional health measures, specifying the public health events, acute or not, that triggered those measures;
 - iii. Consideration should be given to providing States Parties complying with Article 43 with incentives.

Expert advisory groups

61. The Draft GSP still anticipates the establishment of *Technical Advisory Group of Experts on Infectious Hazards*. Therefore, it was recalled that, during the 2016 Consultation, States Parties in the Americas expressed concerns about the establishment of a *Scientific advisory group of experts for infectious hazards*, because of the resources to be invested in the creation of an additional structure of uncertain sustainability, its potential for duplicating functions of the purview of the Emergency or Review IHR Committees, and with the potential to hamper the acute public health event risk assessment process, which is dynamic by definition and needs to be operationally agile to inform an efficient response.

62. In relation to Question 18 (see Annex E) posed to stimulate the discussions during the meeting, participants pointed out that the question was largely redundant since, as per Article 47 of the IHR, the following provisions of the WHO Regulations for Expert Advisory Panels and Committees¹⁹ respectively apply to:

- a) IHR Roster of Experts: “*In the selection of members of expert advisory panels the Director-General shall consider primarily their technical ability and experience, but he shall also endeavour to ensure that the panels have the broadest possible international representation [...]. He/she shall encourage nomination of experts from developing countries and from all regions [...]*”;

¹⁹ World Health Organization. WHO Regulations for Expert Advisory Panels and Committees. WHO, [cited 2017 August 15]. Available from: <http://apps.who.int/gb/bd/PDF/bd47/EN/regu-for-expert-en.pdf>.

- b) Advisory Groups: “[...] the Director-General shall select from one or more expert advisory panels the members of an expert committee on the basis of the principles of equitable geographical representation, gender balance, a balance of experts from developed and developing countries, representation of different trends of thought, approaches and practical experience in various parts of the world, and an appropriate interdisciplinary balance.”.

63. Nevertheless, during the discussion, it emerged that several issues related to the interpretation and application of *Article 47 - Composition [of the IHR Roster of Experts]* remain unclear at national level and warrant further action by the WHO Secretariat and/or PASB. These include:

- a) Purpose of the IHR Roster of Experts. It has to be recalled that the IHR Roster of Experts is the primary source of experts from which members of the IHR Emergency and Review Committees, which are appointed and have an advisory role to the Director-General of WHO, are drawn from. The members of the IHR Roster of Expert, in this specific capacity, are not intended to directly provide advice to States Parties or to be mobilized by them;
- b) Composition and membership of the IHR Roster of Experts. It has to be recalled that members for the IHR Roster of Experts can either be proposed by the WHO Secretariat, being the membership of each expert subject to the clearance of the respective national authorities; by relevant intergovernmental and regional economic integration organizations; or by States Parties. The duration of the membership in the IHR Roster of Experts is four years, and subject to further four extensions;
- c) Procedures related to the management of the IHR Roster of Experts. It has to be noted that, besides Article 47 of the IHR, the WHO Secretariat has not made available written procedures governing the interactions between States Parties, individual experts, and the WHO Secretariat, and detailing all the administrative steps applying to States Parties, individual experts, and the WHO Secretariat;
- d) Publication of the list of members on the IHR Roster of Experts. The list is periodically published by the WHO Secretariat on the EIS secure portal.²⁰

64. It was recalled that, as per Article 47 of the IHR, each State Party has the right to designate an expert for inclusion in the IHR Roster of Experts, so that, should it be affected by an acute public health event triggering the convening of an Emergency Committee, the State Party can make its case, hence preventing the WHO Secretariat from unilaterally recommending public health measures that might unnecessarily negatively affect the State Party. A State Party designated expert should ideally gather both, technical acumen and the ability to argue the State Party’s position. At the time of the meeting, 9 of the 35 States Parties in the Americas had designated their expert. Additionally, States Parties can propose, for consideration by the WHO Secretariat, additional experts for inclusion in the IHR Roster of Experts, because of their specific technical experience and expertise.

65. Participants also expressed some concerns about the transparency of the modus operandi of both, the IHR Roster of Experts, and IHR Emergency and Review Committees:

²⁰ World Health Organization. Event Information Site for National IHR Focal Points. WHO, [cited 2017 August 15, corresponding to update of the IHR Roster of Experts published in December 2016]. Available from: <http://apps.who.int/ihr/eventinformation/system/files/IHRRoster-December2016.pdf>.

- a) Consistency of the WHO Secretariat in including States Parties designated experts as members of IHR Emergency Committee considering an acute public health event in the State Party of origin;
- b) Although experts included in the IHR Roster of Experts upon proposal by the WHO Secretariat are not representing the country of origin when selected as members of IHR Emergency and Review Committees, some States Parties might have objections regarding their selection and would wish to know how these should be conveyed to the WHO Secretariat;
- c) Consistency of the WHO Secretariat in disclosing the memberships of IHR Emergency and Review Committees. It was noted that, following the criticism to the WHO Secretariat for failing to do so when the “*Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009*” was convened, the memberships to other IHR Emergency and Review Committees convened since then have always been disclosed.

66. Considering the challenges and concerns enumerated above, there is a need for the WHO Secretariat and/or PASB to disseminate to States Parties:

- a) Information about the functions of the IHR Roster of Experts, and IHR Emergency and Review Committees;
- b) Detailed procedures regarding the management of the IHR Roster of Experts;
- c) Regular reminders about the States Parties’ right to designate an expert for inclusion in the Roster.

Strategic pillar 3 - Measuring progress and accountability, with focus on the IHR Monitoring and Evaluation Framework

67. As indicated under the heading *Scope of the Draft Five-year Global Strategic Plan*:

- a) Reiterating the comments already expressed during the 2016 Consultation, the vast majority of the participants indicated that, in compliance with Article 54 of the IHR, the IHR MEF should be presented as a stand-alone document for consideration and adoption by the Seventy-first World Health Assembly, May 2018, through the 142nd Executive Board, January 2018;
- b) The titles and respective content of Strategic pillar 2 - *Event management and compliance* – , and Strategic pillar 3 – *Measuring progress and accountability* should be reconsidered. Therefore, the Draft GSP should define and specify the distinction between monitoring and evaluation; between monitoring of the application and implementation of the IHR and monitoring of compliance with the IHR (see also paragraph 15. b));
- c) Participants unanimously agreed, and insisted, that comments to the IHR MEF provided during the 2015 and 2016 Consultations are still valid and that related recommendations formulated should be implemented by the WHO Secretariat.
- d) The IHR MEF reflects a historical conceptually compartmentalized approach to the IHR, with the demonstration of accountability exclusively falling upon States Parties; and with only the sub-set of provisions related to core capacities detailed in Annex 1 of the IHR encompassed by proposed Framework. Therefore, consideration should be

given by the WHO Secretariat to complement the IHR MEF with additional components covering the IHR in their entirety, as well as with components applying to the WHO Secretariat.

68. Recalling that, pursuant to Resolution WHA68.5, the IHR MEF revolves around four components:

- a) One mandatory: State Party Annual Reporting; and
- b) Three voluntary:
 - i. After-Action Reviews;
 - ii. Simulation Exercises;
 - iii. Joint External Evaluations;

During the discussions, the principles underpinning the IHR MEF were given for granted – country ownership, mutual accountability, trust building, transparency, and collective learning exercise.

69. It was noted that, while monitoring and evaluation activities are important to ensure mutual accountability among States Parties, the primary beneficiaries of such efforts should remain States Parties themselves. Similarly, while monitoring and evaluation activities constitute good public health practice, efforts of States Parties and the WHO Secretariat in this regard should not represent an exclusive priority; rather, the focus of the WHO Secretariat should give at least equal focus to more substantial capacity-building activities at national level, aimed at improving sustainability. Additionally, participants pointed out that, since 2015, the WHO Secretariat almost exclusively focused its activities on one voluntary component of the IHR MEF – joint external evaluations.

70. It was noted that some of the controversies surrounding specific components of the IHR MEF that emerged during the debate at the Seventieth World Health Assembly, May 2017, and that ultimately led to the adoption of Decision WHA70(11), revolved around the suggestion that the IHR MEF, to be presented for consideration and adoption by the World Health Assembly, should be inclusive of the tools specific to each of its four components. In this respect, as already expressed during the 2016 Consultation, participants concurred that the IHR MEF, to be presented for consideration and adoption by the World Health Assembly, should be a policy document; and that, taking advantage of the ongoing consultative process, it should undergo further revision by States Parties.

71. Bearing in mind that Article 54 of the IHR – *"States Parties and the Director-General shall report to the Health Assembly on the implementation of these Regulations as decided by the Health Assembly."* – does not restrict the scope of the deliberations of the World Health Assembly related to reporting; and mindful of the sensitivities surrounding the IHR MEF, during the meeting, positions that emerged signaled the constructive willingness of States Parties represented by the participants to identify a common ground for the IHR MEF to stand on solid governance foundations, and hence to achieve institutional closure.

72. Therefore, also taking into account comments and suggestions already expressed during the 2016 Consultation, the IHR MEF, for each of its four components, should include:

- a) Public health rationale and objectives;

- b) Roles and responsibilities of States Parties and the WHO Secretariat;
- c) The extent to which it is complementary to the remaining components, and provide related considerations in terms of cost-effectiveness;
- d) Explicit references to the tool/s supporting the roll-out of the specific component, and to the process underlying its/their development adopted by the WHO Secretariat. Although there was no consensus among the participants because of possible additional delays, it is worthwhile mentioning that, together with the IHR MEF, the WHO Secretariat should ponder presenting the tool related to the mandatory Annual Reporting component to the World Health Assembly for its consideration and adoption;
- e) Frequency of its implementation;
- f) A description of the information that will be presented to the World Health Assembly resulting from the application of the specific component;
- g) How the information produced by the application of the specific component will be used by the WHO Secretariat to inform its country cooperation activities;

73. Additionally, as per recommendations of the “*IHR Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation*”, adopted through Resolution WHA68.5, – “[...] the Secretariat should develop through regional consultative mechanisms options to move from exclusive self-evaluation to [...] additional approaches [...]. Any new monitoring and evaluation scheme should be developed with the active involvement of WHO regional offices and subsequently proposed to all States Parties through the WHO governing bodies’ process.” – and suggestions already expressed by States Parties in the Americas during the 2016 Consultation, participants stressed the following:

- a) Considering the diversity of States Parties, the IHR MEF should explicitly indicate that its operationalization should be determined by the WHO Regional Offices and that States Parties should be granted flexibility to ensure that the Framework will be beneficial at national level. Participants also flagged that PASB might need to provide additional technical clarifications in relation to the IHR MEF, since ambiguities may result from the translation from English to other WHO and PAHO official languages;
- b) The WHO Secretariat must share with the Regional Offices, and, through them, with States Parties, tools being developed to support the roll-out of the IHR MEF. The tools should be shared with enough time for consideration before their roll-out, and in all six WHO official languages. It has to be noted that, as indicated in the Draft GSP, invoking Article 44 of the Regulations, the WHO Secretariat is arrogating the mandate to develop tools related to the IHR MEF. However, considering Article 54 of the IHR, Resolution WHA68.5, and, especially, the outcomes of the formal regional consultations, through the WHO Regional Committees in the 2015 and 2016, the application of Article 44 to reporting circumstances is not appropriate – “*WHO shall collaborate with States Parties, upon request, to the extent possible, in: (a) the evaluation and assessment of their public health capacities in order to facilitate the effective implementation of these Regulations*”;
- c) The IHR MEF should specify the synergies and articulations with related monitoring mechanisms under the auspices of other international organizations.

74. Participants indicated that, if, for some reason, the subsequent versions of the Draft GSP refers to the IHR MEF, for consistency, its four components should be equally represented, by indicating their nature (mandatory versus voluntary), and including references to relevant tools.

75. Participants indicated that PASB should develop and pilot accountability mechanisms, encompassing all IHR provisions, to be applied to PASB, in its capacity of WHO Regional Office for the Americas.

Mandatory State Party Annual Reporting

76. Recalling that the State Party Annual Report, based on a self-administered questionnaire, is the sole mandatory component of the current proposed IHR MEF, participants reiterated concerns and suggestions already expressed during the 2015 and 2016 Consultations. In particular, the shortcomings of the tool currently used, together with those of the derived metrics, warrant thorough review and reconsideration efforts by the WHO Secretariat, taking into account:

- a) The need to ensure that the four components of the IHR MEF are truly complementary, hence based on different methodologies, and are not meant to generate redundant information. This consideration especially applies to the complementarity of the State Party Annual Report and joint external evaluations components;
- b) The need for the tool to be more concise and for the metrics to be based on a graduated scoring system. The tool should be more concise and the metrics should be based on a graduated scoring system. Participants were informed that these topics were discussed during the “*WHO Internal technical meeting on the IHR Monitoring & Evaluation Framework Post 2016*,” New Delhi, India, 1-4 November 2016, and the “*WHO Internal technical meeting on IHR annual reporting tool*,” Geneva, Switzerland, 15-17 March 2017. While work is still in progress, elements of the draft revised tool presented at the meeting included:
 - i. The revised core capacities, only partially overlapping with the technical areas of the joint external evaluation;
 - ii. The color-coded grading scoring system, which is still based on percentages;
 - iii. The fact that the revised tool is larger the questionnaire currently used to submit the States Party Annual Report to the World Health Assembly;
- c) In order to maximize benefits and minimize controversies at national level, the WHO Secretariat should provide some mechanism to ensure coherence and continuity between the tool currently used for the submission of the States Party Annual Report to the World Health Assembly.

77. Recalling that the regional and country specific information related to indicators and core capacities scores is available on the WHO headquarters web page,²¹ for the sake of maximum transparency, participants unanimously requested PASB to make available to States Parties in the Region the States Parties Annual Reports in their entirety (see also paragraph 34. e)).

²¹ World Health Organization. Global Health Observatory (GHO) data. WHO, [cited 2017 August 15]. Available from: <http://www.who.int/gho/ihr/en/>.

Voluntary After-Action Reviews

78. Recalling that States Parties in the Americas are at the origin of the inclusion of after action reviews in the IHR MEF (*Regional Meeting in the Americas on the Implementation of the International Health Regulations (IHR)*, Buenos Aires, Argentina, 29-30 April 2014), participants were informed after-action reviews were discussed during the “*WHO Internal technical meeting on the IHR Monitoring & Evaluation Framework Post 2016*”, New Delhi, India, 1-4 November 2016. Despite efforts by PASB to convey to the WHO Secretariat inputs from the Region received since 2014, and including during the 2015 and 2016 Consultations, the WHO Secretariat has recently developed two technical documents on this matter, failing to take into account the agreements reached during the aforementioned WHO Internal technical meeting, and contributions from the Americas in particular.

79. Therefore, true to the considerations surrounding after-action reviews at their inception – a tool, not only to ensure mutually accountability among States Parties, but also for transparently exercising peer-pressure and for collective learning – participants concurred that an interactive web-based platform should be the basis for implementing voluntary after-action reviews within the IHR Monitoring and Implementation Framework should be piloted in the Americas. It was implicit that, as part of the continuous domestic public health preparedness process, after-action reviews should be systematically conducted by national and local authorities following any acute public health event.

80. Participants indicated that the Americas are technically equipped, including from the IT perspective at PASB level, to pilot after-action reviews through a secure interactive web-based platform. By accessing the interactive web-based platform, States Parties would be indicating their willingness to undertake after-action reviews in the context of the IHR Monitoring and Implementation Framework.

Voluntary Simulation Exercises

81. Participants emphasized that simulation exercises should be first and foremost relevant and useful for the country/ies involved. Therefore, reporting requirements to the World Health Assembly should be regarded as subsidiary. Also, it was pointed out that after-action reviews should be privileged over simulation exercises as tools for triggering and undertaking changes of the public health event/emergency management framework. However, it was underlined that, for some countries, sharing information with the international community about real life events might be politically sensitive and, in those cases, simulation exercises would constitute a more appealing alternative.

82. Even without tackling the specific information related to simulation exercises that should be presented to the World Health Assembly, but notwithstanding that information sharing at international level should not be determined by the positive or negative outcome of a simulation exercise, the characterization of simulation exercises that could be eligible for international reporting – hence, to some extent, meaningful or relevant to other States Parties across the globe – was not conclusive.

83. Noting that, regardless of the methodological approach, scenarios utilized in simulation exercises should be determined by the risk profile of the context in which they are taking place, the most prevailing suggestions offered by the participants regarding the attributes that would make a simulation exercise eligible for reporting to the World Health

Assembly are presented below. However, at this stage, there were not specific indications were given about whether the attribute should be, or not, mutually exclusive.

- a) At least one core capacity detailed in Annex 1 of the IHR should be put to test by the simulation exercise. Some participants were more inclined towards testing a higher minimum number of core capacities;
- b) For smaller size States Parties, active involvement in the simulation exercise of authorities at national level; and, for larger States Parties, active involvement of, at least, authorities at the first sub-national level;
- c) Any multi-country simulation exercise with the active involvement of authorities from the national level of countries concerned;
- d) Simulation exercises involving multiple sectors.

84. Whereas, on one hand, some participants suggested that a standardized protocol should be developed by the WHO Secretariat, on the other hand it was proposed States Parties sharing with PASB information about any simulation exercise conducted within the territory of the country, and leaving at PASB's discretion the triage and selection of those that are deemed to be informative at global level.

85. Although participants pointed out that PASB, with respect to other WHO Regional Offices, is better equipped to support States Parties in conducting simulation exercises, they also indicated that there is a need for guidance documents for the planning of simulation exercises. Participants were informed that the WHO Secretariat, at headquarters level, has recently published the WHO Simulation Exercise Manual.²² It was noted that the WHO Regional Offices were not consulted about the development of that material.

Voluntary Joint External Evaluations

86. Participants insisted that concerns and suggestions regarding the joint external evaluations, expressed during the 2015 and 2016 Consultations, should be taken into account by the WHO Secretariat as part of the ongoing consultative process. These are summarized below and complemented by those made during the meeting, also triggered by the presentation by PASB of the outline of the proposed process for conducting voluntary external valuations in the Americas.

- a) Recognizing that joint external evaluations as an end to themselves are virtually meaningless, voluntarily hosting a joint external evaluation is regarded as good public health practice, as well as a sign of transparency and commitment. However, expectations currently generated by joint external evaluations might not be realistic and uncertainties were expressed about their immediate and long terms impact in terms of contributing to the attainment of sustainable national resource allocation. It was stressed that the achievement of sustainable results can only rely on the engagement and commitment of the Government as a whole, beyond the Ministry of Health and beyond the Ministry of Finance, to ensure that there is political and financial leverage to take sustained actions, including budgetary adjustments. It was stressed that, volunteering to host a joint external evaluation in reaction to the actual or

²² World Health Organization WHO Simulation Exercise Manual. WHO; 2017, [cited 2017 August 15]. Available from: <http://www.who.int/ihr/publications/WHO-WHE-CPI-2017.10/en/>.

perceived failure in managing an acute public health event might be a double-edged sword since the political attention generated by a health crisis could rapidly fade;

- b) There are concerns about the financial sustainability, falling upon the WHO Secretariat and/or PASB, of conducting joint external evaluations both, in the immediate and longer terms. While some participants pointed out that, if the WHO Secretariat and PASB are promoting joint external evaluations, States Parties would give for granted the availability of funds to do so, PASB indicated that this is not the case, at least in the foreseeable future.
- c) The content of the current joint external evaluation tool is regarded as not necessarily aligned with IHR provisions, WHO existing guidelines, and does not take into account “access to certain core capacities” as an alternative to having capacity in-country, which is of particular concern to Small Island States. Therefore, the tool should undergo considerable scrutiny. Participants were informed that the “*WHO Meeting on Review of Joint Evaluation Tool*” was held in Geneva, Switzerland, on 19-21 April 2017. However, while work is still in progress, the outcome of the revision exercise does not seem to address this issue;
- d) The outline of the process for conducting voluntary joint external evaluations in the Americas was presented by PASB and participants expressed their overall agreement with the proposed approach. Notwithstanding that expertise mobilize to conduct joint external evaluations should aim at catering for the anticipated needs of any given country at best, as already expressed during the 2015 and 2016 Consultations, the vast majority of the participants insisted about the fact that external mission teams should build on regional expertise, with knowledge of the national language and context.
- e) Participants indicated that PASB should provide more specific information about the timeframe for completing the joint external evaluation process, from the time PASB receives a request from national authorities to the publication of the outcome of the joint external evaluation, including the specific time lags between the different phases and indications about PASB’s anticipated response time.

87. Noting that PAHO made available a draft translation into Spanish of the joint external evaluation tool, the outline of the process for conducting voluntary joint external evaluations in the Americas proposed by PASB follows. Besides comments and suggestions captured in the paragraphs above, participants expressed their overall agreement with the proposed process. PASB will be sharing with States Parties in the Region a revised version of the process.

- i. Voluntary - as documented by a formal request for hosting a joint external evaluation to the PAHO Secretariat signed by the Minister of Health, possibly jointly with the Minister of Finance;
- ii. Two-phase process to be conducted under the leadership of the PAHO Secretariat;
 - The overall process is expected to take two to three months;
- iii. National evaluation preceding the in-country external mission can be facilitated by the PAHO Secretariat upon explicit request by national authorities;
- iv. In-country external mission teams to be assembled and proposed by the PAHO Secretariat and cleared by national authorities;

- v. In-country external missions to be conducted by professionals speaking the language of the country, preferably from the Region;
- vi. External mission teams to include:

- Peers: national authorities identified following survey to pre-determine availability of individual professionals and expertise. Declaration of Interest and Confidentiality Agreement will have to be signed;
- Subject Matter Experts on very specific topics mobilized on the basis of needs emerged from past evaluations, from the national evaluation preceding the in-country external mission, or upon explicit request by national authorities. Subject Matter Experts would be drawn by the PAHO Secretariat from the IHR Roster of Experts, networks of PAHO Consultants. Declaration of Interest and Confidentiality Agreement will have to be signed;
- Staff of Specialized UN Agencies (IAEA-PAHO agreement, World Bank, OIE, International Civil Aviation Organization (ICAO));
- PAHO Secretariat staff, with strong presence of Health Systems staff;

Mission team's members are expected to dedicate a total of two weeks full-time work to the joint external evaluation;

- vii. The two-phase process, regarded as part of the continuum national planning-financing-monitoring and evaluation process, will privilege, right from inception:
 - Past related evaluations, existing initiatives, and States Parties commitments under other PAHO and WHO Resolutions, as well as other international agreements. This to cater for countries' specific needs at best by avoiding a one-size-fits-all approach;
 - The integration of core capacities detailed in the Annex 1 of the IHR in the existing national planning and financing mechanisms as EPHFs, both within the health sector and interministerially;
 - Technical areas that are known to be weaker, and not already addressed by other extensive PAHO/WHO Programs;
- viii. National expectations regarding the short- and long-term outcomes of the two-phase process to be explicitly indicated in the formal letter by national authorities to the PAHO Secretariat requesting it to conduct and to host the joint external evaluation, including regarding the publication of the Country Report;
- ix. The implementation of joint external evaluations by the PAHO Secretariat will be subject to the availability of funds.

Conclusions

88. With respect to the 2015 and 2016 Consultations, participants urged the WHO Secretariat to be more transparent in conducting the process through which the inputs to the Draft GSP received as a result of the ongoing consultative process will be incorporated in the Final Draft of the Five-year Global Strategic Plan that will be presented to the 142nd WHO Executive Board in January 2018. To this effect, the Who Secretariat should inform States Parties accordingly as soon as possible.

89. As part of the ongoing global consultative process for the elaboration of the final Draft GSP, PASB invited the participants to ensure that their respective States Parties be represented at the formal consultation of Member States, due to take place in Geneva, Switzerland, in November 2017, by officials well versed in issues related to the Draft GSP and IHR MEF.

90. Participants were informed that PASB was going to share with them for comments the draft report of the meeting by 28 July 2017, and that comments, to be consolidated by country and provided with change tracking enabled, should be sent back to PASB by 4 August 2017. Similarly, they were informed that the report of the meeting would to be presented to the 29th Pan American Sanitary Conference/69th Session of the Regional Committee of WHO for the Americas.

91. Participants agreed that, in order to take forward the position of the Region of the Americas vis-à-vis the WHO Governing Bodies, PASB should propose either a Decision or a Resolution for consideration and adoption by the 29th Pan American Sanitary Conference/69th Session of the Regional Committee of WHO for the Americas.

Annex A: Five-year Global Strategic Plan to improve public health preparedness and response - Consultation with Member States, 3 July 2017



DRAFT

Information document

**WHE/CPI/IHR
3 July 2017**

Five-year Global Strategic Plan to improve public health preparedness and response

Consultation with Member States

SUMMARY

1. This document is prepared for consultation among Member States at the WHO Regional Committees, to be held in 2017, on the five-year global strategic plan to improve public health preparedness and response, as requested by the Health Assembly Decision WHA70(11).¹ It includes a review of issues raised by Member States during the 70th World Health Assembly on this topic, a review of the mandates given by the Health Assembly to the WHO Secretariat with regards to the implementation of the International Health Regulations (2005) (IHR), and a proposed way forward for the consultative process to develop the draft five-year global strategic plan for submission to the 71st World Health Assembly in 2018. The Annex to this document presents an annotated draft outline of the five-year global strategic plan proposed by the WHO Secretariat.

BACKGROUND

2. As requested by Health Assembly's decision WHA69(14), the WHO Secretariat developed a draft global implementation plan for the recommendations of the Review Committee on the Role of the IHR in the Ebola Outbreak and Response, which was presented to the 70th Health Assembly in May 2017². The document incorporated suggestions from extensive consultations with all Regional Committees, and included six areas of action for taking forward the recommendations of the Review Committee, and 12 guiding principles for the 5-year global strategic plan to improve public health preparedness and response.
3. The 70th Health Assembly noted the global implementation plan and requested the Director-General, through decision WHA70(11), "to develop, in full consultation with Member States, including through the regional committees, a draft five-year global strategic plan to improve public health preparedness and response, based on the guiding principles contained in Annex 2 of document A70/16, to be submitted for consideration and adoption by the Seventy-first World Health Assembly, through the Executive Board at its 142nd session."

¹ Decision WHA70(11): [http://apps.who.int/gb/ebwha/pdf_files/WHA70/A70\(11\)-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA70/A70(11)-en.pdf)

² Document A70/16: http://apps.who.int/gb/ebwha/pdf_files/WHA70/A70_15-en.pdf

4. This paper presents a review of issues raised by Member States during the 70th World Health Assembly on this topic, a review of the mandates given by the Health Assembly to the WHO Secretariat with regards to the implementation of the IHR, and a proposed way forward for the consultative process to finalize the five-year global strategic plan. The annex to this document presents an annotated draft outline of the 5-year global strategic plan proposed by the WHO Secretariat for consultation among Member States at the WHO Regional Committees in 2017.

ISSUES RAISED BY MEMBER STATES DURING THE 70TH WORLD HEALTH ASSEMBLY

IHR Monitoring and Evaluation Framework

5. The main issue for which divergent views were raised by Member States during the 70th Health Assembly was the proposed IHR Monitoring and Evaluation framework (MEF). Summary records of the deliberations are available at this link³.
6. The majority of Member States appreciated WHO's leadership in rolling out the new and voluntary components of the IHR Monitoring and Evaluation Framework, including the joint external evaluation. This was considered by some Member States as a powerful tool for effectively acquiring the core capacities required under the IHR. These Member States also appreciated that the process of external evaluation is rolled-out as "a package", whereby the evaluation is planned together with the development of national action plans for public health preparedness and response. Some Member States considered that the technical guidance developed by the Secretariat for monitoring and reporting on IHR implementation should be "evidence-based, neutral and never subject to political influence". Some Member States stressed the need to take into account regional resources to achieve access to core capacities, particularly in the context of small countries, such as Small Island States.
7. Five Member States expressed substantial reservations and concerns with regards to the joint external evaluation and the Monitoring and Evaluation Framework. They have requested that new instruments for monitoring, evaluation and reporting should be presented to and adopted by the WHO Governing Bodies. One Member State also considered that the introduction of external evaluations and other new mechanisms not provided by the IHR may require amendments to the IHR. Another concern was in relation to national sovereignty, and specifically the fact that the "external evaluation should not become a precondition for receiving financial and technical assistance".

Integrate IHR core capacities and resilient health systems

8. There was overwhelming realisation following the Ebola virus diseases outbreak in West Africa in 2014-2015, that strong and resilient health systems are an underlying factor for well-functioning core capacities of the IHR. Member States were unanimous in acknowledging the critical importance of strong resilient health systems for the implementation of IHR, and the need to integrate IHR core capacities with essential public health functions, within the framework of universal health coverage. They requested the WHO Secretariat to develop specific guidance on how to support countries, in particular resource-constraint ones, in building their IHR core capacities. The UHC Forum 2017 on Universal Health Coverage, co-hosted by Japan, WHO and the World Bank in December 2017, is expected to provide a framework and a roadmap for building resilient health systems through the framing of IHR core capacities as health systems' essential public health functions.

Other issues

9. Additional comments and interventions were related to developing the national action plans, supporting the National IHR Focal Points, developing tools for international early warning system,

³ http://apps.who.int/gb/e/e_wha70.html - to be replaced with final one when ready

and risk assessment. These elements will be addressed by the 5-year global strategic plan to improve public health preparedness and response.

10. The issues of research and development in emergency situations, information and sample sharing, and overall administration and functioning of the WHO Health Emergencies Programme were also raised by many Member States, but they are not included in this document, as the WHO Secretariat will produce separate documents on those issues for the 71st Health Assembly.

MONITORING AND EVALUATION OF IHR CORE CAPACITIES – MANDATES AND TECHNICAL WORK TO DATE

11. The International Health Regulations (2005) are legally binding on 196 States Parties, including all 194 WHO Member States. They were adopted by the Health Assembly in May 2005 and entered into force on 15 June 2007. Following the entry into force of the IHR, States Parties had five years “to strengthen, develop and maintain (...) the capacity to detect, assess, notify and report events” and “to respond promptly and effectively to public health risk and public health emergencies of international concern”, including required capacity at designated airports, ports and ground crossings, as described in Annex 1 of the IHR. For States Parties that were not able to meet these minimum requirements in the first five years, the IHR provided for two two-year extensions (2012-2014 and 2014-2016) to comply with them. The WHO Secretariat and partners have provided and continue to provide technical support but still an estimated **xx** States Parties do not meet the core capacities required under the IHR.
12. Article 54.1 of the IHR requires that “States Parties and the Director-General shall report to the Health Assembly on the implementation of these Regulations as decided by the Health Assembly”, which also comprises monitoring the status of core capacities. In 2008, the Health Assembly, through Resolution WHA61.2, decided that “States Parties and the Director-General shall report to the Health Assembly on the implementation of the Regulations annually (...)”. Resolution WHA61.2 also requested the Director-General “to submit every year a single report, including information provided by States Parties and about the Secretariat’s activities, to the Health Assembly for its consideration (...)”. In 2009 and 2010, the online questionnaire sent out by the WHO Secretariat to States Parties focused mainly on self-reported processes related to the establishment and functioning of the National IHR Focal Points.⁴
13. In 2010, the WHO Secretariat produced a technical guide to support States Parties in fulfilling their reporting obligations under the IHR (2005).⁵ The guide proposed a country-led process to self-assess and report on the status of IHR core capacities described in Annex 1 of the IHR. An IHR core capacity monitoring framework was subsequently developed by the Secretariat.⁶ This framework included a checklist and 28 indicators that States Parties used to self-assess and report annually to the WHA on the status of eight core capacities and additional capacities at points of entry and four specific hazards covered by the Regulations, notably biological (zoonotic, food safety and other infectious hazards), chemical, radiological and nuclear. The self-assessment tool, completed and submitted by States Parties to the WHO Secretariat on an annual basis, constituted the basis for compiling the report on the implementation of the IHR by the Secretariat to the Health Assembly. States Parties’ specific scores related to the status of each core capacity were included in the Secretariat’s annual implementation report to the World Health Assembly from

⁴ Implementation of the International Health Regulations (2005). Report by the Director-General. Documents A62/2 and A63/5

⁵ WHO Protocol for assessing national surveillance and response capacities for the International health Regulations (2005), in accordance with Annex 1 of the IHR. WHO/HSE/IHR/2010.7 Available at: http://www.who.int/ihr/publications/who_hse_ihr_201007_en.pdf?ua=1

⁶ IHR Core capacities monitoring framework: checklist and indicators for monitoring progress in the development and implementation of the IHR core capacities in States Parties. WHO/HSE/GCR/2013.2. Available at: http://apps.who.int/iris/bitstream/10665/84933/1/WHO_HSE_GCR_2013.2_eng.pdf?ua=1

2011 to 2016.⁷ From 2016 these scores were made available online through the WHO Global Health Observatory.⁸

14. In 2015, the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation recommended to move “from exclusive self-evaluation to approaches that combine self-evaluation, peer review and voluntary external evaluations involving a combination of domestic and independent experts.”⁹ Resolution WHA68.5 urged Member States to support the implementation of the recommendations of the Review Committee and WHO to present an update to the Sixty-ninth World Health Assembly on progress made in taking forward the recommendations of the Review Committee. WHO Secretariat then developed a concept note outlining a new approach for monitoring and evaluation of IHR core capacities.¹⁰ The concept note was discussed by the WHO regional committees in 2015, and a revised monitoring and evaluation framework was presented to, and noted by, the Sixty-ninth World Health Assembly in 2016.¹¹
15. The IHR Monitoring and Evaluation Framework has four complementary components: the mandatory States Parties’ annual self-reporting required under the International Health Regulations (2005), and three voluntary components: joint external evaluation, after-action review and simulation exercises. As part of its function and mandate under the IHR (article 44.2), WHO Secretariat is developing technical tools for each of the three voluntary components. To ensure coherence and consistency between the various instruments, the WHO Secretariat will review the annual self-reporting tool, and this revised instrument will be proposed to States Parties for future annual reporting.
16. The Director-General will establish a scientific advisory group to advise the Secretariat on its work on monitoring and reporting on IHR implementation and compliance. The group will be established based on the Regulations for Expert Advisory Panels and Committees¹², and will have broad representation, including from government and non-government organizations, and from all geographical regions.

PROPOSED WAY FORWARD

17. In preparation for the development of the 5-year global strategic plan, requested by Decision WHA70(11), the WHO Secretariat has prepared this issue paper, which highlights the area of monitoring and evaluation of IHR implementation as the main issue to be brought for further consultation. The paper also includes a draft annotated outline of the 5-year global strategic plan in the annex to this document, and is meant to be used for consultation during the 6 Regional Committees between August and October 2017.
18. The WHO Secretariat will also present this issue paper to the six Regional Coordinators of the Geneva Mission Focal Points in an information session during the month of July 2017. In addition, the WHO Secretariat is planning a web-based consultation on the issue paper between mid-July to mid-October 2017.

⁷ Documents A64/9, A65/17, A66/16 and A66/16Add1, A67/35 and 67/35Add1, A68/22

⁸ <http://www.who.int/gho/ihr>

⁹ WHA 68.5. The recommendations of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation. Available at: http://apps.who.int/gb/ebwha/pdf_files/WHA68-REC1/A68_R1_REC1-en.pdf#page=27

¹⁰ Development, monitoring and evaluation of functional core capacity for implementing the International Health Regulations (2005): concept note, available at: http://www.who.int/ihr/publications/concept_note_201507/en/

¹¹ Document A69.20 Implementation of the International Health Regulations (2005). Annual report on the implementation of the International Health Regulations (2005). Report by the Director-General. Available at: http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_20-en.pdf

¹² Regulations for Expert Advisory Panels and Committees. Available at: <http://apps.who.int/gb/bd/PDF/bd47/EN/regu-for-expert-en.pdf>

19. Building on the outline of the five-year global strategic plan proposed in the annex, the outcome of the Member States consultations that will be taking place at the Regional Committees in 2017, the WHO Secretariat will further refine the draft plan, and will organize a face-to-face formal consultation of Member States in Geneva, Switzerland on 2-3 November 2017. The final version of the 5-year global strategic plan will be submitted to the 142nd Executive Board.

ACTION BY THE REGIONAL COMMITTEES

20. The Regional Committees are invited to review the annotated outline for the 5-year global strategic plan, including to provide their views on the IHR monitoring and evaluation framework.

ANNEX

ANNOTATED OUTLINE OF THE DRAFT 5 YEAR GLOBAL STRATEGIC PLAN TO IMPROVE PUBLIC HEALTH PREPAREDNESS AND RESPONSE

1. This annotated outline recalls the guiding principles presented in document A70/16 and propose three strategic pillars for public health preparedness and response for sustained implementation of the International Health Regulations (2005). The goal is to strengthen capacities at the global, regional and country levels to prepare, detect, assess and respond to public health risks and emergencies with the potential for international spread.

Guiding Principles for the 5-year global strategic plan to improve public health preparedness and response¹³

Guiding principle	Details
1. Consultation	<p>Consultative process from May to November 2017 through Regional Committees, web-based consultation, and information session with Regional Coordinators of the Geneva-based missions.</p> <p>One formal consultation of Member States to be held in Geneva, Switzerland, on 2-3 November 2017.</p>
2. Country ownership	<p>Building and sustaining core capacities as essential public health functions of their health system, at national and subnational level, is the primary responsibility of national governments, taking into account their national health, social, economic, security and political contexts.</p>
3. WHO Leadership and governance	<p>The WHO Health Emergencies Programme will lead the development and implementation of the global five-year strategic plan to improve public health preparedness and response. The WHO Secretariat will report on progress to the governing bodies, as part of regular reporting on the application and implementation of the International Health Regulations (2005).</p>
4. Broad partnerships	<p>Many countries require technical support to assess, build and maintain their core capacities as essential public health functions of their health systems. Many global partners support countries in the field of health system strengthening and public health preparedness and response.</p> <p>As decided by the 58th Health Assembly, WHO will cooperate and coordinate its activities, as appropriate, with the following: United Nations, International Labour Organization, Food and Agriculture Organization, International Atomic Energy Agency, International Civil Aviation Organization, International Maritime Organization, International Committee of the Red Cross, International Federation of Red Cross and Red Crescent Societies, International Air Transport Association, International Shipping Federation, and Office International des Epizooties. Cooperation with other relevant non-State actors and industry associations will also be considered, within the WHO Framework of Engagement with Non-State Actors (FENSA).</p>
5. Intersectoral approach	<p>Responding to public health risks, events and emergencies requires a multisectoral, coordinated approach, (for example with agriculture, transport, tourism, and finance sectors). Many countries already have health coordination platforms or mechanisms in place, such as the “One-Health” approach. The five-year global strategic plan will provide strategic orientation for planning for public health preparedness and response across multiple sectors.</p>

¹³ For details, see Annex 2 of Document A70/16

6. Integration with health systems	The Ebola virus disease outbreak in West Africa in 2014-2015 has put both health security and health system resilience high on the development agenda. Framing the core capacities detailed in Annex 1 of the IHR as essential public health functions will mutually reinforce health security and health systems, leading to resilient health systems.
7. Community involvement	Effective public health preparedness can only be achieved with the active participation of local governments, civil society organizations, local leaders, and individual citizens. Communities must take ownership of their preparedness and strengthen it for emergencies that range in scale from local or national events to pandemics and disasters.
8. Focus on fragile contexts	While the WHO Health Emergencies Programme is supporting all countries in their preparedness for and response efforts vis-a-vis public health risks, events, and emergencies, the initial focus will be on a set of priority countries in fragile situations. The identification of priority countries will take into account an assessment of national core capacities and other risk assessments, for example using the INFORM methodology ¹⁴ .
9. Regional integration	Building on the five-year global strategic plan, the WHO Regional Offices will develop regional operational plans, taking into account existing regional frameworks and mechanisms, such as: The Regional Strategy for Health Security – a strategy of the Regional Office for Africa, the Asia Pacific Strategy for Emerging Diseases – a common strategic framework for the regions of South-East Asia and the Western Pacific, Health 2020 – a policy framework and strategy for the European Region, the Regional Assessment Commission for the International Health Regulations (2005) established by the Regional Committee for the Eastern Mediterranean Region, and other regional approaches.
10. Domestic financing	<p>For long-term sustainability, the budgeting and financing of core capacities as essential public health functions should be supported to the extent possible from domestic resources. The WHO Secretariat will work with countries to encourage the allocation of domestic financial resources to build and sustain essential public health functions within the context of existing national planning and financing mechanisms.</p> <p>In countries that require substantial external resources the WHO Secretariat will provide support for strengthening the institutional mechanisms for coordinating international cooperation, based on the principles of effective development cooperation (country ownership, focus on results, inclusive partnerships, transparency and accountability¹⁵).</p>
11. Linking the 5-year global strategic plan with requirements under the IHR (2005)	The five-year global strategic plan will propose strategic directions in relation to the relevant IHR requirements for States Parties and for WHO, as well as voluntary operational and technical aspects that are not a requirement under the International Health Regulations (2005).
12. Focus on results, including monitoring and accountability	The five-year global strategic plan will have its own monitoring framework, including indicators and timelines, which will be developed through the consultative process, and used for annual reporting on progress to the Health Assembly.

¹⁴ INFORM Index for Risk Management is a tool for understanding the risk of humanitarian crises and disasters. Available at: <http://www.inform-index.org/Portals/0/InfoRM/INFORM%20Global%20Results%20Report%202017%20FINAL%20WEB.pdf?ver=2016-11-21-164053-717>

¹⁵ Global Partnership for Effective Development Cooperation – principles. (Available at: <http://effectivecooperation.org/about/principles/>. Accessed 1 May 2017).

Strategic pillar 1. Building and maintaining State Parties Core Capacities

2. In view of lessons learned from the Ebola virus disease outbreak in West Africa in 2014-2015 and other recent acute public health events, States Parties should focus on building and maintaining resilient health systems, and on framing core capacities as essential public health functions of their health systems. While complying with requirements to ensure mutual accountability at international level with respect to the application and implementation of the IHR, countries need to establish domestic monitoring and evaluation mechanisms as part of their health systems, which would also facilitate the monitoring of the status of core capacities, as essential public health functions.
3. The implications and potential gains in terms of continuity in certain country capacities that will be triggered by the transition of the Global Polio Eradication initiative towards a Post-Certification Strategy will have to be considered. The 70th Health Assembly requested the Director General to develop a “strategic polio transition action plan by the end of 2017 to be submitted for consideration by the Seventy-first World Health Assembly through the Executive Board at its 142nd session, that clearly identifies the capacities and assets, especially at country and where appropriate community levels, that are required to sustain progress in other programmatic areas, such as disease surveillance; immunization and health systems strengthening; early warning, emergency and outbreak response, including the strengthening and maintenance of IHR core capacities”.
4. State Parties had almost 10 years to put in place core capacities to prevent, detect, assess, report and respond to public health risks, events, and emergencies with potential to spread internationally, in accordance with IHR requirements. States Parties should continue to build and maintain these core capacities as essential public health functions of their health systems, for the effective application of the IHR implementation, including those capacities related to points of entry.
5. For those States Parties where the existing national planning, financing, and monitoring and evaluation mechanisms of their health systems are sub-optimal, the WHO Secretariat will develop guidance to facilitate the building and maintenance of core capacities, as essential public health functions, as part of the continuum of the assessment and planning process, and in alignment with the health national strategy. Similarly, the WHO Secretariat will develop guidance to facilitate the national approach to inter-sectoral planning and financing. WHO will develop guidance and provide technical support to countries to develop these plans. The development of the national action plans should be aligned with national health sector’s strategies and plans, and, in their development and implementation, they should emphasize coordination of multiple sectors and partners, such as OIE and FAO under the “One Health” approach. Because the core capacities required under the Regulations cut across several sectors, financial and other sectors should be part of the planning process to ensure cross-sector coordination and appropriate financial allocations.

Strategic pillar 2. Event management and compliance

6. The WHO Secretariat and States Parties should continue to fulfil their obligations under the IHR in relation to detection, assessment, notification, reporting of and response to public health risks and events with potential for international spread. The role of the National IHR Focal Points will have to be strengthened, including through technical guidance, standard operating procedures, training, information sharing and lessons learning activities.
7. The WHO Secretariat will strengthen its functions for event-based surveillance through the newly developed Epidemic Intelligence from Open Sources (EIOS) platform for early detection and risk assessment of acute public health events.
8. The WHO Secretariat will strengthen its role in administering the expert advisory groups established to support the application, implementation of, and compliance with the IHR, i.e.

Roster of Expert for the Emergency and Review Committees, the scientific and technical advisory group on yellow fever geographical risk mapping, and the ad-hoc advisory group on aircraft disinsection for controlling the international-spread of vector-borne diseases. It will also pursue the establishment of the Technical Advisory Group of Experts on Infectious Hazards based on the terms of reference in Annex 3 of document A70/16.

9. A critical element for the optimal functioning of the global alert and response system is compliance by States Parties with the IHR requirements in relation to health measures taken in response to public health risks and events, including during Public Health Emergencies of International Concern. The WHO Secretariat, in compliance with Article 43, will share with States Parties procedures related to the systematic reporting, collection, monitoring, and dissemination of information related to additional health measures implemented by States Parties. It will systematically collect information on additional measures, and it will request the public health rationale and the scientific evidence for those measures that significantly interfere with international traffic.

Strategic pillar 3. Measuring progress and accountability

10. An important element for global health preparedness and response is the continuous monitoring of progress, both in establishing and maintaining by States Parties of the core capacities detailed in Annex 1 of the IHR, and in the ability of the global system to respond to acute public health events with potential of international spread.
11. Article 54.1 of the IHR requires “States Parties and the Director-General shall report to the Health Assembly on the implementation of these Regulations as decided by the Health Assembly”. This also comprises monitoring the status of core capacities detailed in Annex 1 of the IHR. The annual frequency of reporting to the Health Assembly was determined by the World Health Assembly Resolution WHA61.2. Since 2010, the WHO Secretariat has proposed a self-assessment tool, exclusively focusing on core capacities, for States Parties to fulfil their annual reporting obligation to the Health Assembly. In compliance with Article 54 of the IHR, and with Resolution WHA68.5, as a result of the consultations during the WHO Regional Committees in 2017, the 5-year global strategic plan will propose a revised IHR Monitoring and Evaluation Framework for reporting to the Health Assembly on the status of the application and implementation of the IHR.
12. In the interim, WHO Secretariat will continue to propose the self-assessment annual reporting tool, introduced in 2010, while at the same time responding to requests from Member States that would like to implement additional monitoring and evaluation instruments as part of the IHR monitoring and evaluation framework.
13. The 5-year global strategic plan will include indicators and timelines for measuring progress at global and regional level. Most regions already have specific strategies and frameworks that will be taken into account in developing the monitoring approach for the 5-year global strategic plan.

Annex B: Development of a draft five-year global strategic plan to improve public health preparedness and response - Consultation with Member States, 1 August 2017



Information document

WHE/CPI/IHR
1 August 2017

Development of a draft five-year global strategic plan to improve public health preparedness and response

Consultation with Member States

SUMMARY

1. This document has been prepared for consultation with Member States at the sessions of the regional committees in 2017, in order to develop a draft five-year global strategic plan to improve public health preparedness and response, as requested in decision WHA70(11) (2017). It includes: issues raised by Member States on implementation of the International Health Regulations (2005) during the Seventieth World Health Assembly; the mandates and technical work carried out by the Secretariat on monitoring and evaluation of the core capacities required by the Regulations; and a proposed way forward for the consultative process for the development of the draft five-year global strategic plan. The Annex to this document contains the guiding principles and pillars proposed by the Secretariat for the five-year global strategic plan.

BACKGROUND

2. In response to decision WHA69(14) (2016), the Secretariat developed a draft global implementation plan for the recommendations of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response. The final version of the global implementation plan was submitted to the Seventieth World Health Assembly in May 2017,¹ through the Executive Board at its 140th session in January 2017. The finalized global implementation plan incorporated proposals from extensive consultations with all six regional committees, and included six areas of action for taking forward the recommendations of the Review Committee, and 12 guiding principles for the five-year global strategic plan to improve public health preparedness and response.

¹ Document A70/16.

3. The Seventieth World Health Assembly took note of the report containing the global implementation plan and through decision WHA70(11) requested the Director-General, “to develop, in full consultation with Member States, including through the regional committees, a draft five-year global strategic plan to improve public health preparedness and response, based on the guiding principles contained in Annex 2 to document A70/16, to be submitted for consideration and adoption by the Seventy-first World Health Assembly, through the Executive Board at its 142nd session”.

ISSUES RAISED BY MEMBER STATES ON IMPLEMENTATION OF THE INTERNATIONAL HEALTH REGULATIONS (2005) DURING THE SEVENTIETH WORLD HEALTH ASSEMBLY

IHR Monitoring and Evaluation Framework

4. The main issue for which divergent views were raised by Member States during the Seventieth World Health Assembly was the proposed IHR Monitoring and Evaluation framework.²

5. The majority of Member States appreciated the Secretariat’s leadership in implementing the new and voluntary components of the IHR Monitoring and Evaluation Framework, including the joint external evaluation. This was considered by some Member States as a powerful tool for effectively acquiring the core capacities required by the International Health Regulations (2005). These Member States also appreciated the fact that the process of external evaluation is implemented as a package, whereby the evaluation is planned together with the development of national action plans for public health preparedness and response. Some Member States considered that the technical guidance developed by the Secretariat for monitoring and reporting on implementation of the Regulations should be evidence-based, neutral and never subject to political influence. Some Member States stressed the need to take into account regional resources to achieve the core capacities required by the Regulations, particularly in the context of small countries, such as small island States.

6. A few Member States expressed substantial reservations and concerns with regard to the joint external evaluation and the IHR Monitoring and Evaluation Framework. They requested that new instruments for monitoring, evaluation and reporting should be submitted to and adopted by the WHO governing bodies. Other Member States considered that the introduction of external evaluations and other new mechanisms not provided by the Regulations may require amendments to the Regulations. Another concern was in relation to national sovereignty: it was considered that the external evaluation should not become a precondition for receiving financial and technical assistance.

Integrating core capacities required by the International Health Regulations (2005) and resilient health systems

7. There was an overwhelming realisation by Member States following the Ebola virus disease outbreak in West Africa in 2014 and 2015 that strong and resilient health systems are an underlying factor for well-functioning core capacities required by the Regulations. Member States were unanimous in acknowledging the critical importance of strong resilient health systems for the implementation of the Regulations, and the need to integrate the core capacities required by the Regulations with essential public health functions, within the framework of universal health coverage. They requested the Secretariat to develop specific guidance on how countries, in particular those that face resource constraints, could be supported in building their core capacities required by the Regulations. A forum on universal health coverage in December 2017 – co-organized by the World Bank, WHO, UNICEF, UHC2030, the Government of Japan and the Japan International Cooperation Agency³ – is expected to provide a framework and a road map for building resilient health systems

² See the provisional summary records of the Seventieth World Health Assembly, Committee A, first, second, fourth and seventh meetings.

³ See https://www.uhc2030.org/fileadmin/uploads/uhc2030/Documents/Upcoming_events/UHC_Forum_2017/Flyer_for_UHC_Forum_2017.pdf (accessed 20 July 2017).

through the framing of core capacities required by the International Health Regulations (2005) as essential public health functions of health systems.

Other issues

8. Additional comments were related to developing the national action plans for public health preparedness and response, supporting the National IHR Focal Points, developing tools for an international early warning system, and risk assessment.

9. The issues of research and development in emergency situations, data and sample sharing, and overall administration and functioning of the WHO Health Emergencies Programme were also raised by many Member States, but they are not included in this document, as these will be addressed in separate reports on the WHO Health Emergencies Programme to the Seventy-first World Health Assembly in 2018.

MONITORING AND EVALUATION OF CORE CAPACITIES REQUIRED BY THE INTERNATIONAL HEALTH REGULATIONS (2005): MANDATES AND TECHNICAL WORK OF THE SECRETARIAT TO DATE

10. The International Health Regulations (2005) are legally binding on 196 States Parties, including all 194 WHO Member States. They were adopted by the Health Assembly in May 2005⁴ and entered into force on 15 June 2007. Following the entry into force, States Parties had five years to “develop, strengthen and maintain ... the capacity to respond promptly and effectively to public health risks and public health emergencies of international concern”,⁵ including the core capacity requirements for designated airports, ports and ground crossings, as described in Annex 1 to the Regulations. For States Parties that were not able to meet these minimum requirements in the first five years, the Regulations provided for two two-year extensions (2012–2014 and 2014–2016) to allow States Parties time to comply.

11. Article 54.1 of the Regulations requires that “States Parties and the Director-General shall report to the Health Assembly on the implementation of these Regulations as decided by the Health Assembly”, which also comprises monitoring the status of core capacities. In 2008, the Health Assembly, through resolution WHA61.2, decided that “States Parties and the Director-General shall report to the Health Assembly on the implementation of the Regulations annually”. That resolution also requested the Director-General “to submit every year a single report, including information provided by States Parties and about the Secretariat’s activities, to the Health Assembly for its consideration”. In 2008 and 2009, a questionnaire was sent by the Secretariat to States Parties, focused mainly on self-reported processes related to the establishment and functioning of the National IHR Focal Points.⁶

12. In 2010, the Secretariat developed and shared with States Parties a core capacity monitoring framework,⁷ with a questionnaire for States Parties to complete on a voluntary basis on the status of implementation of the Regulations. This framework included a checklist and 20 indicators on the status of eight core capacities and capacities at points of entry and four specific hazards covered by the Regulations, notably biological (zoonotic diseases, food safety events and other infectious hazards), chemical, radiological and nuclear events. The self-assessment tool, completed and submitted by States Parties to the Secretariat on an annual basis (from 2010 to 2017), constituted the basis for compiling the report on the implementation of the Regulations by the Secretariat to the Health Assembly. States Parties’ specific scores related to the status of each core capacity were included in

⁴ See resolution WHA58.3 (2005).

⁵ International health regulations (2005) – 3rd edition. Geneva: World Health Organization; 2016. Article 13.1.

⁶ See documents A62/6 and A63/5.

⁷ IHR core capacity monitoring framework: checklist and indicators for monitoring progress in the development of IHR core capacities in States Parties. Available at: http://apps.who.int/iris/bitstream/10665/84933/1/WHO_HSE_GCR_2013.2_eng.pdf?ua=1 (accessed 17 July 2017).

the Secretariat's annual implementation report to the Health Assembly from 2013 to 2015.⁸ From 2015, these scores were made available online through the Global Health Observatory.⁹

13. In 2015, the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation recommended that the Secretariat should develop options to move “from exclusive self-evaluation to approaches that combine self-evaluation, peer review and voluntary external evaluations involving a combination of domestic and independent experts”.¹⁰ Resolution WHA68.5 (2015) urged Member States to support the implementation of the recommendations of the Review Committee and requested the Director-General to present an update to the Sixty-ninth World Health Assembly on progress made in taking forward the recommendations of the Review Committee. The Secretariat then developed a concept note outlining a new approach for monitoring and evaluation of the core capacities required by the Regulations.¹¹ The concept note was discussed by the regional committees in 2015, and a revised monitoring and evaluation framework was submitted to, and noted by, the Sixty-ninth World Health Assembly in 2016.¹²

14. The revised IHR Monitoring and Evaluation Framework submitted to the Health Assembly in 2016 comprises four complementary components: the mandatory annual self-reporting by States parties in accordance with resolution WHA61.2 (2008) on implementation of the Regulations, and three voluntary components: joint external evaluation, after-action review and/or simulation exercise(s). As part of its function and mandate under the Regulations,¹³ the Secretariat is developing technical tools for each of the three voluntary components. The IHR Monitoring and Evaluation Framework is an important part of pillar 3 of the draft five-year global strategic plan to improve public health preparedness and response (see the Annex to this document).

PROPOSED WAY FORWARD FOR THE CONSULTATIVE PROCESS FOR THE DEVELOPMENT OF THE DRAFT FIVE-YEAR GLOBAL STRATEGIC PLAN

15. The current document highlights the area of monitoring and evaluation of implementation of the Regulations as the main issue to be brought for further consultation in preparing for the development of the draft five-year global strategic plan.

16. In addition to consulting Member States at the sessions of the regional committees between August and October 2017, the Secretariat is also planning a web-based consultation on the document between mid-August and mid-October 2017.

17. The input received from Member States at the sessions of the regional committees will be used by the Secretariat to further refine the draft plan. The Secretariat will also organize a face-to-face consultation of Member States through the Geneva-based mission focal points. The consultation is planned to take place in Geneva in November 2017. The updated version of the draft five-year global strategic plan will be submitted to the Executive Board at its 142nd session in 2018.

ACTION BY THE REGIONAL COMMITTEES

18. The regional committees are invited to review the guiding principles and pillars of the five-year global strategic plan, and to provide their views on the IHR Monitoring and Evaluation Framework.

⁸ Documents A64/9, A65/17, A66/16 and A66/16 Add.1, A67/35 and A67/35 Add.1 and A68/22.

⁹ See <http://www.who.int/gho/ihr> (accessed 17 July 2017).

¹⁰ See WHA68/2015/REC/1, Annex 2.

¹¹ Development, monitoring and evaluation of functional core capacity for implementing the International Health Regulations (2005). Concept note. Available at: http://www.who.int/ihr/publications/concept_note_201507/en/ (accessed 17 July 2017).

¹² See document A69/20.

¹³ Resolution WHA58.3 (2005), Article 44.2 and Annex 1.

ANNEX

FIVE-YEAR GLOBAL STRATEGIC PLAN TO IMPROVE PUBLIC HEALTH PREPAREDNESS AND RESPONSE: GUIDING PRINCIPLES AND PILLARS

This Annex recalls the guiding principles contained in document A70/16 and proposes three pillars for public health preparedness and response. The goal of the plan is to strengthen capacities at the global, regional and country levels to prepare for, detect, assess and respond to public health risks and emergencies with the potential for international spread. The guiding principles are outlined in the table.

Table. Guiding principles for the five-year global strategic plan to improve public health preparedness and response¹

Guiding principle	Details
1. Consultation	Consultative process from May to November 2017 through the regional committees and a web-based consultation. One formal consultation of Member States, through the Geneva-based mission focal points, is planned to be held in Geneva, in November 2017.
2. Country ownership	Building and sustaining core capacities as required by the International Health Regulations (2015) as essential public health functions of their health systems, at the national and subnational levels, is the primary responsibility of national governments, taking into account their national health, social, economic, security and political contexts.
3. WHO leadership and governance	The WHO Health Emergencies Programme will lead the development and implementation of the five-year global strategic plan. The WHO Secretariat will report on progress to the meetings of the governing bodies, as part of the regular reporting on the application and implementation of the International Health Regulations (2005).
4. Broad partnerships	Many countries require technical support to assess, build and maintain their core capacities as required by the Regulations as essential public health functions of their health systems. Many global partners support countries in the field of health systems strengthening and public health preparedness and response. As decided by the Fifty-eighth World Health Assembly, WHO will cooperate and coordinate its activities, as appropriate, with the following: the United Nations, ILO, FAO, IAEA, ICAO, IMO, International Committee of the Red Cross, International Federation of Red Cross and Red Crescent Societies, IATA, International Shipping Federation and OIE. Cooperation with other relevant non-State actors and industry associations will also be considered, within the Framework of Engagement with Non-State Actors.

¹ Based on document A70/16, Annex 2.

Guiding principle	Details
5. Intersectoral approach	Responding to public health risks, events and emergencies requires a multisectoral, coordinated approach (for example, with agriculture, transport, tourism and finance sectors). Many countries already have health coordination platforms or mechanisms in place, such as the One-Health approach. The five-year global strategic plan will provide strategic orientation for planning for public health preparedness and response across multiple sectors.
6. Integration with the health system	The Ebola virus disease outbreak in West Africa in 2014 and 2015 put both health security and health systems resilience high on the development agenda. Framing the core capacities detailed in Annex 1 to the Regulations as essential public health functions will mutually reinforce health security and health systems, leading to resilient health systems.
7. Community involvement	Effective public health preparedness can only be achieved with the active participation of local governments, civil society organizations, local leaders, and individual citizens. Communities must take ownership of their preparedness and strengthen it for emergencies that range in scale from local or national events to pandemics and disasters.
8. Focus on fragile contexts	While the WHO Health Emergencies Programme is supporting all countries in their preparedness and response efforts in relation to public health risks, events and emergencies, the initial focus will be on a set of priority countries in fragile situations. The identification of priority countries will take into account an assessment of national core capacities and other risk assessments, for example using the INFORM methodology. ²
9. Regional integration	Building on the five-year global strategic plan, the regional offices will develop regional operational plans, taking into account existing regional frameworks and mechanisms, such as: the regional strategy for health security and emergencies 2016–2020 – a strategy of the Regional Office for Africa; ³ the Asia Pacific Strategy for Emerging Diseases and Public Health Emergencies (APSED III) – a common strategic framework for the regions of South-East Asia and the Western Pacific; ⁴ Health 2020 – a policy framework and strategy for the European Region; ⁵ the Regional Assessment Commission for the International Health Regulations (2005) established by the Regional Committee for the Eastern Mediterranean, ⁶ and other regional approaches.

² INFORM Index for Risk Management is a tool for understanding the risk of humanitarian crises and disasters. Available at: <http://www.inform-index.org/Portals/0/InfoRM/INFORM%20Global%20Results%20Report%202017%20FINAL%20WEB.pdf?ver=2016-11-21-164053-717> (accessed 17 July 2017).

³ See <http://www.afro.who.int/sites/default/files/2017-07/afr-rc66-6-en-2107.pdf> (accessed 20 July 2017).

⁴ See http://www.wpro.who.int/about/regional_committee/67/documents/wpr_rc67_9_apsed.pdf (accessed 1 August 2017)

⁵ See http://www.euro.who.int/_data/assets/pdf_file/0011/199532/Health2020-Long.pdf?ua=1 (accessed 20 July 2017).

⁶ See http://applications.emro.who.int/docs/RC62_Resolutions_2015_R3_16576_EN.pdf?ua=1 (accessed 20 July 2017).

Guiding principle	Details
10. Domestic financing	For long-term sustainability, the budgeting and financing of core capacities required by the Regulations as essential public health functions should be supported to the extent possible from domestic resources. The Secretariat will work with countries to encourage the allocation of domestic financial resources to build and sustain essential public health functions within the context of existing national planning and financing mechanisms. In countries that require substantial external resources, the Secretariat will provide support for strengthening the institutional mechanisms for coordinating international cooperation, based on the principles of effective development cooperation (country ownership, focus on results, inclusive partnerships, transparency and accountability). ⁷
11. Linking the five-year global strategic plan with requirements under the International Health Regulations (2005)	The five-year global strategic plan will propose strategic directions in relation to the relevant Regulations requirements for States Parties and for WHO, as well as voluntary operational and technical aspects that are not a requirement under the Regulations.
12. Focus on results, including monitoring and accountability	The five-year global strategic plan will have its own monitoring framework, including indicators and timelines, which will be developed through the consultative process, and used for annual reporting on progress to the Health Assembly.

Pillars

1. Building and maintaining State Parties core capacities required by the International Health Regulations (2005)

(a) In view of lessons learned from the Ebola virus disease outbreak in West Africa in 2014 and 2015 and other recent public health events, States Parties should focus on building and maintaining resilient health systems, and on framing core capacities as essential public health functions of their health systems. While complying with requirements to ensure mutual accountability at international level with respect to the application and implementation of the IHR, countries need to establish domestic monitoring and evaluation mechanisms as part of their health systems, which would also facilitate the monitoring of the status of core capacities, as essential public health functions.

(b) The implications and potential gains, in terms of continuity of certain country capacities that will be triggered by the transition of the Global Polio Eradication initiative towards a post-certification strategy, will have to be considered. The Seventieth Health Assembly requested the Director-General, inter alia, “to develop a strategic action plan on polio transition by the end of 2017, to be submitted for consideration by the Seventy-first World Health Assembly, through the Executive Board at its 142nd session, that: (i) clearly identifies the capacities and assets, especially at country and, where appropriate, community levels, that are required to: sustain progress in other programmatic areas, such as: disease surveillance; immunization and health systems strengthening; early warning, emergency and

⁷ Global Partnership for Effective Development Co-operation – principles. Available at: <http://effectivecooperation.org/about/principles/> (accessed 17 July 2017).

outbreak response, including the strengthening and maintenance of core capacities of core capacities under the International Health Regulations (2005)".⁸

(c) State Parties have had slightly more than 10 years to put in place core capacities to prevent, detect, assess, report and respond to public health risks, events and emergencies with potential to spread internationally, in accordance with the requirements of the Regulations. States Parties should continue to build and maintain these core capacities as essential public health functions of their health systems, for the effective application of the implementation of the Regulations, including those capacities related to points of entry.

(d) For those States Parties where the existing national planning, financing, and monitoring and evaluation mechanisms of their health systems are suboptimal, the Secretariat will develop guidance to facilitate the building and maintenance of core capacities, as essential public health functions, as part of the continuum of the assessment and planning process, and in alignment with the national health strategy. Similarly, the Secretariat will develop guidance to facilitate the national approach to intersectoral planning and financing. The Secretariat will develop guidance and provide technical support to countries to develop these plans. The development of the national action plans should be aligned with the national health sector's strategies and plans, and, in their development and implementation, they should emphasize coordination of multiple sectors and partners, such as OIE and FAO, under the One Health approach. Because the core capacities required under the Regulations cut across several sectors, financial and other sectors should be part of the planning process to ensure cross-sector coordination and appropriate financial allocations.

2. Event management and compliance

(a) The Secretariat and States Parties should continue to fulfil their obligations under the Regulations in relation to detection, assessment, notification and reporting of and response to public health risks and events with the potential for international spread. The role of the National IHR Focal Points will have to be strengthened, including through the provision of technical guidance, standard operating procedures, training, information sharing and lessons-learned activities.

(b) The Secretariat will strengthen its functions for event-based surveillance through the newly developed Epidemic Intelligence from Open Sources platform for early detection and risk assessment of public health events.

(c) The Secretariat will strengthen its role in administering the expert advisory groups established to support the application and implementation of and compliance with the Regulations, that is, the roster of experts for the emergency and review committees, the scientific and technical advisory group on geographical yellow fever risk mapping, and the ad hoc advisory group on aircraft disinsection for controlling the international spread of vector-borne diseases. It will also pursue the establishment of the Technical Advisory Group of Experts on Infectious Hazards, based on the draft terms of reference in Annex 3 to document A70/16.

(d) A critical element for the optimal functioning of the global alert and response system is compliance by States Parties with the requirements of the Regulations in relation to health

⁸ See decision WHA70(9).

measures taken in response to public health risks and events, including during public health emergencies of international concern. The Secretariat, in compliance with Article 43 of the Regulations, will share with States Parties information related to additional health measures implemented by States Parties. It will systematically collect information on additional measures, and, for measures that significantly interfere with international traffic under Article 43, it will share with other States Parties the public health rationale and the scientific evidence provided by the States Parties implementing those measures.

3. Measuring progress and accountability

(a) An important element for global health preparedness and response is the continuous monitoring of progress, both in establishing and maintaining by States Parties of the core capacities detailed in Annex 1 to the Regulations, and in the ability of the global system to respond to public health events with the potential for international spread.

(b) Article 54.1 of the Regulations requires that “States Parties and the Director-General shall report to the Health Assembly on the implementation of these Regulations as decided by the Health Assembly”. This also comprises monitoring the status of core capacities detailed in Annex 1 to the Regulations. The annual frequency of reporting to the Health Assembly was determined by the Sixty-first World Health Assembly in 2008.⁹ Since 2010, the Secretariat has proposed a self-assessment tool, exclusively focusing on core capacities, for States Parties to fulfil their annual reporting obligation to the Health Assembly. In compliance with Article 54 of the Regulations on reporting and review, and with resolution WHA68.5 (2015) on the recommendations of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation, and as a result of the consultations during the regional committees in 2017, the five-year global strategic plan will propose a revised IHR Monitoring and Evaluation Framework for reporting to the Health Assembly on the status of the application and implementation of the Regulations.

(c) In the interim, the Secretariat will continue to propose the self-assessment annual reporting tool, introduced in 2010, while at the same time responding to requests from Member States that would like to implement additional monitoring and evaluation instruments as part of the IHR Monitoring and Evaluation Framework. As mentioned in document A70/16, which was noted by the Seventieth World Health Assembly in 2017, in order to ensure coherence and consistency between the various instruments, the Secretariat will review the annual self-reporting tool, and this revised instrument will be proposed to States Parties for future annual reporting.

(d) The five-year global strategic plan will include indicators and timelines for measuring progress at the global and regional levels. Most regions already have specific strategies and frameworks that will be taken into account in developing the monitoring approach for the five-year global strategic plan.

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⁹ See resolution WHA61.2 (2008).

Annex C: List of Participants

Formal Regional Consultation on the International Health Regulations (IHR)

Sao Paulo, Brazil, 17-19 July 2017

Lista de Participantes

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Annex D: Agenda

Formal Regional Consultation on the International Health Regulations (IHR)

Sao Paulo, Brazil, 17-19 July 2017

Provisional Programme

Monday, 17 July 2017, Day 1		
Time	Topic	Details
08.00-08.30	Registration	
08.30-08.45	Opening of the meeting	Ministry of Health of Brazil PAHO/WHO
08.45-09.00	PAHO Latin American and Caribbean Center on Health Sciences Information (BIREME)	PAHO/WHO/BIREME
09.00-09.15	Logistics, objectives, and work methodology of the Consultation	PAHO/WHO
09.15-09.30	Introduction of the participants	
09.30-10.00	Status of application, implementation, and compliance with the IHR in the Americas, including presentation of relevant PAHO and WHO Governing Bodies Documents, Decisions, and Resolutions	PAHO/WHO
10.00-10.15	<i>Coffee break</i>	
10.15-10.45	Session 1: Introduction of Group work	PAHO/WHO
	Five-year Global Strategic Plan to improve public health preparedness and response (Five-year Global Strategic Plan) – “Consultation with Member States” paper <ul style="list-style-type: none"> - Scope <ul style="list-style-type: none"> - Five-year Global Strategic Plan to improve public health preparedness and response and IHR Monitoring and Evaluation Framework - Relationship between Five-year Global Strategic Plan and Regional Operational Plans - Relationship between the Five-year Global Strategic Plan and the WHO and PAHO Biennial Work Plans 2018-2019 - Articulation of the Five-year Global Strategic Plan with Plans of other relevant International organizations - Consultative process with Member States - Principles underpinning the Five-year Global Strategic Plan - Outline of the Five-year Global Strategic Plan - Mechanisms for measuring progress in the implementation of the Five-year Global Strategic Plan 	
10.45-12.30	Session 1: Group work	Three/four groups (Facilitators and breakout rooms to be communicated)
12.30-13.30	<i>Lunch</i>	

Monday, 17 July 2017, Day 1		
Time	Topic	Details
13.30-14.30	Session 1: Presentation of Group work and discussion	Rapporteurs (one per group)
14.30-15.00	Session 2: Introduction of Group work	PAHO/WHO
	Strategic pillar 3: Measuring progress and accountability <ul style="list-style-type: none"> - Mechanisms for measuring progress in the implementation of the Five-year Global Strategic Plan - (“a”) Revised IHR Monitoring and Evaluation Framework <ul style="list-style-type: none"> - Compulsory self-assessment - Voluntary After-action review of public health events - Voluntary Simulation exercises - Voluntary Joint and external evaluations - Presentation of information to the World Health Assembly - Articulation with other international Monitoring and Evaluation mechanisms 	
15.00-15.15		<i>Coffee break</i>
15.15-17.00	Session 2: Group work	Three/four groups (Facilitators and breakout rooms to be communicated)
17.00-18.00	Session 2: Presentation of Group work and discussion	Rapporteurs (one per group)
19.30		<i>Dinner</i>

Tuesday, 18 July 2017, Day 2		
Time	Topic	Details
08.30-09.30	Session 3: Introduction of Group work	PAHO/WHO
	Strategic pillar 1: Building and maintaining State Parties Core Capacities <ul style="list-style-type: none"> - Strategy for Universal Access to Health and Universal Health Coverage (15min) - Implementation of the IHR as part of the health systems strengthening process <ul style="list-style-type: none"> - Framing core capacities as essential public health functions - Building and maintaining resilient health systems - Planning, financing, and monitoring and evaluation mechanisms: a continuum within the context of the National health strategy - Inter-ministerial articulations related to planning and financing - Resource mobilization 	
09.30-10.30	Session 3: Group work	Three/four groups (Facilitators and breakout rooms to be communicated)
10.30-10.45	<i>Coffee break</i>	
10.45-11.30	Session 3: Group work – Continued	Three/four groups (Facilitators and breakout rooms to be communicated)
11.30-12.30	Session 3: Presentation of Group work and discussion	Rapporteurs (one per group)
12.30-13.30	<i>Lunch</i>	
13.30-14.00	Session 4: Introduction of Group work	PAHO/WHO
	Strategic pillar 1: Building and maintaining State Parties Core Capacities <ul style="list-style-type: none"> - National IHR Focal Points (<i>also Strategic pillar 2: Event management and compliance</i>) - Chemical hazard - Radiation-related hazard - Human Resources - Points of Entry 	
14.00-16.15	Session 4: Group work	Three/four groups (Facilitators and breakout rooms to be communicated)
16.15-16.30	<i>Coffee break</i>	
16.30-17.30	Session 4: Presentation of Group work and discussion	Rapporteurs (one per group)
19.30	<i>Dinner</i>	

Wednesday, 19 July 2017, Day 3		
Time	Topic	Details
08.30-09.00	Session 5: Introduction of Group work	PAHO/WHO
	Strategic pillar 2: Event management and compliance <i>Part 1</i> <ul style="list-style-type: none"> - Event management - Event detection - Risk assessment - Information dissemination - Response, including adoption of potential Additional Health Measures <i>Part 2</i> <ul style="list-style-type: none"> - WHO expert advisory groups - Roster of Experts (IHR Emergency and Review Committees) - Scientific and technical advisory group on yellow fever geographical risk mapping (GRYF) - Establishment of the Technical Advisory Group of Experts on Infectious Hazards 	
09.00-10.30	Session 5: Group work – <i>Part 1</i>	Three/four groups (Facilitators and breakout rooms to be communicated)
10.30-10.45	<i>Coffee break</i>	
10.45-12.00	Session 5: Group work – <i>Part 2</i>	Three/four groups (Facilitators and breakout rooms to be communicated)
12.00-13.00	Session 5: Presentation of Group work and discussion	Rapporteurs (one per group)
13.00-14.00	<i>Lunch</i>	
14.00-16.15	Plenary discussion: <ul style="list-style-type: none"> - Summary of inputs to the Five-year Global Strategic Plan - Summary of inputs to shape the Regional Operation Plan - Actions vis-à-vis the 29th PanAmerican Sanitary Conference/69th WHO Regional Committee for the Americas 	
16.15-16.30	Closing of the meeting	Ministry of Health of Brazil PAHO/WHO
16.30-17.00	<i>Coffee break</i>	
19.30	<i>Dinner</i>	

Annex E: Questions

Scope of the Draft Five-year Global Strategic Plan

Question 1. Should the IHR Monitoring and Evaluation Framework be embedded in the Draft Five-year Global Strategic Plan, or should the two documents follow two separate paths vis-à-vis the WHO Governing Bodies?

Question 2. How can the Draft Five-year Global Strategic Plan achieve a balance in catering for the needs of both priority countries in fragile situations and non-priority countries?

Question 3. Is there a need to develop a stand-alone Five-year Regional Operational Plan separately from the PAHO Biennial Work Plans (2018-2019 and beyond)?

Question 4. In the absence of a stand-alone a stand-alone Five-year Regional Operational Plan, would PASB's current planning and delivery mechanisms for technical cooperation sufficient to accommodate and absorb what needs to be done to support countries in terms of preparedness and response in the Americas?

Strategic pillar 1 - Building and maintaining State Parties Core Capacities

Question 5. States Parties in the Americas have indicated the need for the WHO Secretariat and/or PASB to develop a conceptual framework bridging essential public health functions and core capacities detailed in Annex 1 of the IHR. Is there still a need for them to do so?

Question 6. Based on the experience of the last ten years in using the IHR as a tool for establishing and maintaining core capacities, what planning, budgetary, and other resource allocation mechanisms should be adopted, or improved, to further strengthen and make those capacities sustainable?

Question 7. Considering the heterogeneity of national planning processes across the Region, is there a need for support from PASB to assess the need to strengthen the existing national planning processes, so that the elements related to essential public health functions (core capacities detailed in Annex 1 of the IHR) can be incorporated there, thus avoiding duplication by creating subsidiary plans dedicated to the IHR?

Question 8. Financial resources are not the only type of resource at play. Is there a need for PASB to support the planning, budgeting or other resource allocation processes in order to determine the need for resources and the characterization of the type of resources?

Question 9. How should Country Cooperation Strategies (CCS) be articulated either with the PAHO Biennial Work Plans (2018-2019 and beyond), or the Five-year Regional Operational Plan? Insert link to CCS?

Question 10. What are the challenges faced at national level in identifying and activating institutional mechanisms to facilitate intersectoral actions (e.g. how to approach joint

planning exercises; how to develop specific inter-ministerial agreements)? Is there a need for PASB to prepare a note/document outlining possible approaches?

Strategic pillar 2 - Event management and compliance

National IHR Focal Point (NFP)

Question 11. What are the main challenges for the NFP to comply with their mandatory functions detailed in Article 4 of the IHR?

Question 12. In order to support NFP in strengthening and maintaining their mandatory functions, what action should be incorporated in the Draft Five-year Global Strategic Plan? [the Draft Five-year Global Strategic Plan refers to technical guidance, standard operating procedures, training, information sharing and lessons learning activities]?

Question 13. In order to support NFP in strengthening and maintaining their mandatory functions, what action should be incorporated in the PAHO Biennial Work Plans (2018-2019 and beyond), or the Five-year Regional Operational Plan?

Management of acute public health events

Question 14. What strategies should be reflected in the Draft Five-year Global Strategic Plan to strengthen the event management (detection/ risk assessment/ information sharing/ response)?

Question 15. Considering that WHO Secretariat is developing a new web-based epidemic intelligence tool, what should be the characteristics of this tool to support countries in public health event management?

Additional health measures

Question 16. Because of the perceived asymmetric treatment of different States Parties by the WHO Secretariat, in order to improve transparency, should actions for the development of a standardized process for the monitoring and management of additional health measures, including the escalation pathway in cases of noncompliance, be included in the Five-year Global Strategic Plan as a participatory process involving States Parties?

Question 17. Any considerations regarding the extent to which bilateral dialogues between countries should be an integral part of the process to resolve controversies resulting from the adoption of health measures, including additional ones?

Expert advisory groups

Question 18. How to ensure all regions are equally represented in the Advisory Groups and IHR Roster of Experts?

Strategic pillar 3. - Measuring progress and accountability, with focus on the IHR Monitoring and Evaluation Framework

Question 20. Would comments to the IHR Monitoring and Evaluation Framework provided by States Parties in the Americas during the 2015 and 2016 formal Consultations still apply? (Comments by States Parties in the Americas are presented in Annex B of Document CD55/12 Rev.1.)

Question 21. Should the IHR Monitoring and Evaluation Framework be presented to the World Health Assembly as a package - also including tools, information to presented, modalities for information sharing with different audiences and format of the feedback provided to Member States?

Question 22. To ensure transparency, and considering issues raised by Member States during the 70th World Health Assembly, should the WHO Secretariat launch a global consultative process to revise the IHR Monitoring and Evaluation Framework presented in Document A69/20, or the package described above?

Voluntary After-Action Reviews

Question 23. Should the Region of the Americas be a pathfinder and pilot this component of the IHR Monitoring and Evaluation Framework as a priority matter through an interactive platform (e.g. adapted EIS), given that this was not captured in the documents developed at global level?

Voluntary Simulation Exercises

Question 24. What should be the attributes that would make a simulation exercise eligible for voluntary reporting to the World Health Assembly (e.g. involvement of the national level, nature of the involvement of the national level, methodological approach [Discussion-based exercises (tabletop exercises), Operations-based exercises (Drills, Functional Exercises, and Field/Full-Scale Exercises)], concreteness of the outcome of the exercise (e.g. adjustments of national plans, documented changes of practice, changes of policy))?

Voluntary Joint External Evaluations

Question 25. Taking into consideration the prioritization given by the WHO Secretariat to joint external evaluations, as well as the comments received by States Parties in the Americas in 2015 and 2016, the PAHO Secretariat is proposing an approach to joint and external evaluations tailored to the Americas and detailed below. Is there agreement regarding the elements of the proposed protocol?